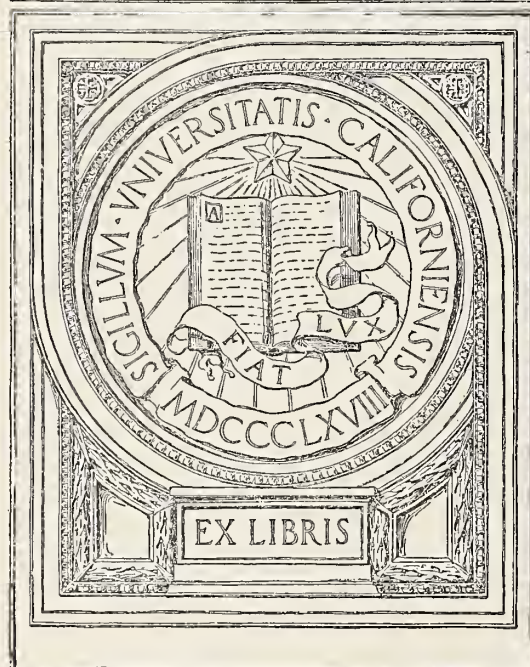


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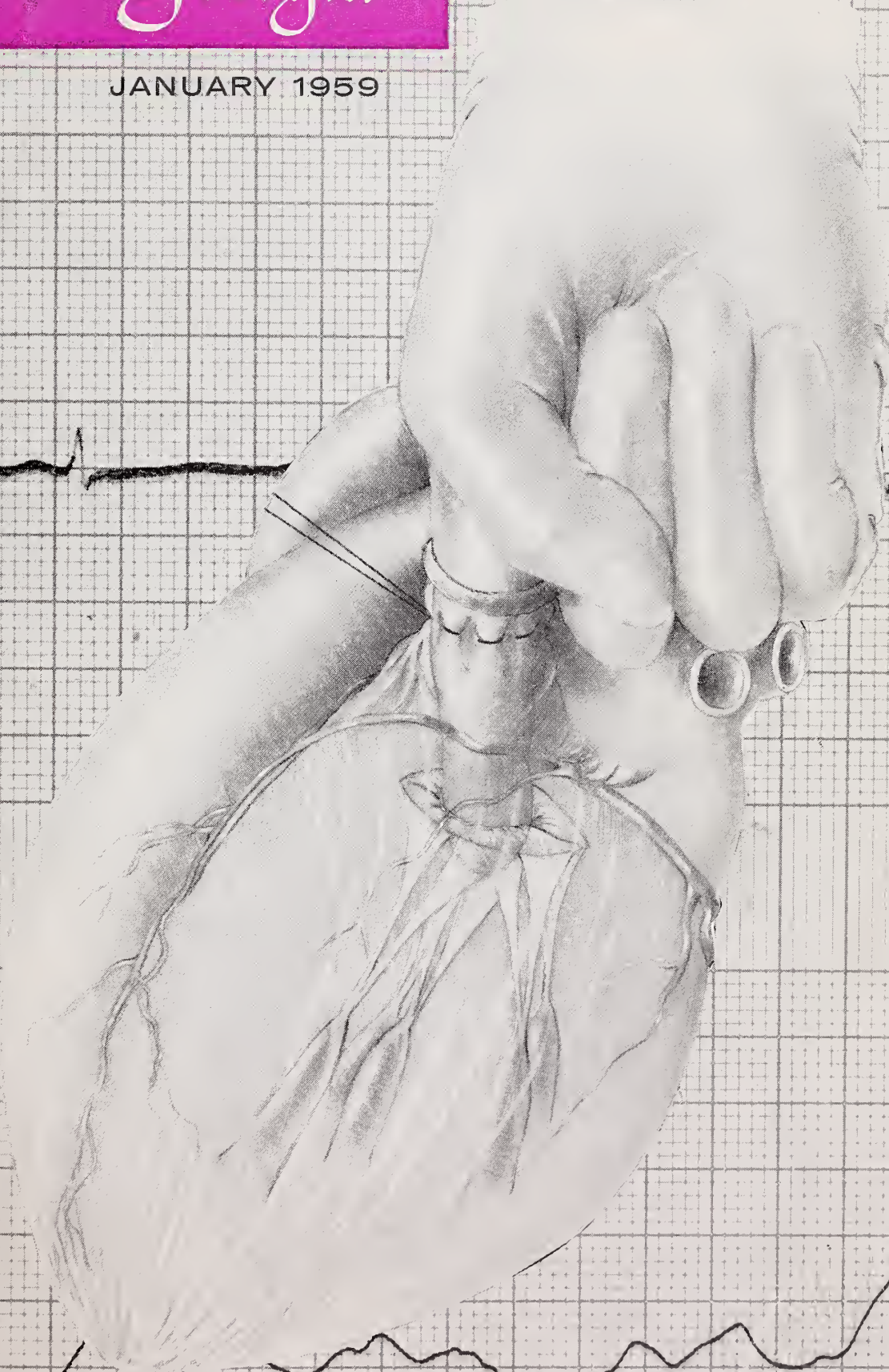
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INTRACARDIAC SURGERY

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THE PRESENT STATUS OF INTRACARDIAC SURGERY

Robert G. Ellison, M.D., *Augusta*

DURING THE PAST ten years intracardiac abnormalities have been operated upon with increasing success. After the successful surgical correction of extracardiac congenital defects it was natural that the field of intracardiac surgery should develop.^{1,2,3,4} Many ancillary developments, such as the improvement in techniques of thoracic surgery and in techniques of anesthesia, the advent of antibiotics, the development of the technique of cardiac catheterization with the resulting increased knowledge of cardiac disease and cardiac physiology, the successful utilization of hypothermia and, more recently, the development of a pump oxygenator have all contributed significantly to progress in the surgical management of intracardiac lesions. Also, the emphasis that modern society and particularly the medical profession has placed upon scientific investigation has contributed greatly to tremendous progress being made in cardiac surgery.

Development of the pump oxygenator in its present form is the result of considerable laboratory and clinical investigation. Several types of oxygenators are being used clinically with a reasonable degree of satisfaction, most of them being variants of the bubble or film method. The membrane type is in an earlier stage of development and is being used on a very small scale although it gives promise

of becoming a much more satisfactory oxygenator than either of the other types. While several types of pump oxygenators are available commercially, most of them have to be modified considerably to obtain the desired results. It is anticipated that rapid progress will be made in the further development of such oxygenators. We are currently using the film method (modified Gibbon screen type) (Figure 1) after having abandoned the bubble system about a year ago.* Blood flows equivalent to full cardiac output are obtained in small or large dogs and in patients up to about 40 Kg body weight. For the larger adult flows considerably higher can be obtained with the film method than with the bubble type. At the same time, problems such as cerebral air embolism, excessive hemolysis, bleeding, etc. that occurred with the bubbling system have been almost entirely eliminated. During cardiopulmonary by-pass operations careful monitoring by means of arterial and venous pressures, electrocardiogram, electroencephalogram, and blood chemical studies have been valuable in helping us understand the effects of the pump oxygenator and in improving its efficiency. Because of the increasing success with open repair of intracardiac lesions, utilization of the pump oxygenator for repair of all such defects should be considered.

In 1902 Sir Lauder Brunton⁵ suggested the feasibility of the surgical correction of mitral stenosis, emphasizing that successful repair of stenosis of the mitral valve depended upon mastering of certain technical details. Thereafter, many outstanding surgeons attempted to produce mitral stenosis experimentally and to develop techniques for its correc-

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*Other members of the surgical team are William H. Moretz, M.D., Edwin L. Brackney, M.D., David P. Hall, M.D., Burton M. Heine, M.D., and Thomas Yeh, M.D.

**These experimental studies are being supported by grants from the Georgia Heart Association and the U. S. Public Health Service.

INTRACARDIAC SURGERY / Ellison

tion. Cutler⁶ in 1924 operated upon the first patients, all unsuccessfully; most of them developed serious mitral insufficiency when the valve leaflets were incised by a valvulotome passed retrogradely through the wall of the left ventricle. As early as 1925 the present day approach to the mitral valve was utilized by Souttar,⁷ but unfortunately the advantages of this approach from above through the left atrial appendage were not realized until nearly 25 years later when Harken⁸ and Bailey⁹ applied this technique on a larger scale. By means of insertion of the index finger into the left atrial appendage the status of the mitral valve is carefully evaluated. Most often the adherent anterolateral commissure can be separated by digital manipulation, but occasionally the densely adherent commissure has to be incised with a valvulotome inserted into the atrium along the side of the finger (Figure 2).

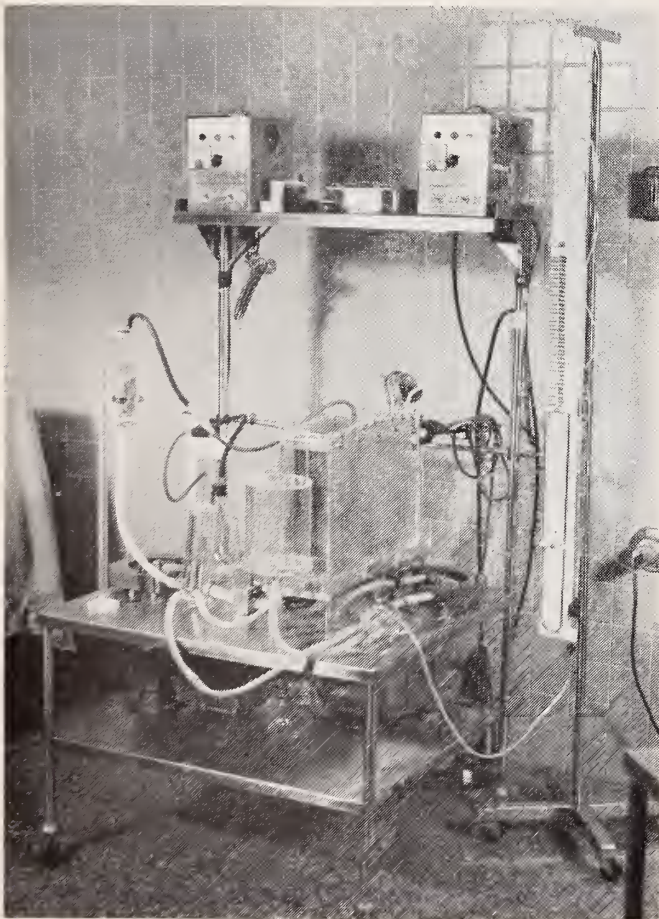


Figure 1. Photograph of screen (Modified Gibbon) type pump oxygenator currently in use at the Eugene Talmadge Memorial Hospital.

During the past ten years experience with surgery of this disease has clarified the indications for and the results expected from commissurotomy.¹⁰ By proper selection of cases, worthwhile improvement can be expected in 75 per cent of patients with an

overall mortality of about five per cent. Although excellent results are usually obtained, occasionally these valves are so rigid that results of this blind technique leave much to be desired. This is particularly true in those with some degree of associated insufficiency. These valves sometimes become more competent, provided satisfactory commissurotomy has been obtained. On the other hand, sometimes regurgitation is accentuated. Relief of stenosis and correction of insufficiency under such circumstances can be better obtained by direct exposure with commissurotomy and valvuloplasty being performed under direct vision. This technique probably will be utilized with increasing frequency.¹¹ There is every reason to believe that with further improvement in the techniques of open heart surgery and in the pump oxygenator one can look forward to reconstructing or replacing the mitral valve under direct vision.

Not only is mitral insufficiency a more serious

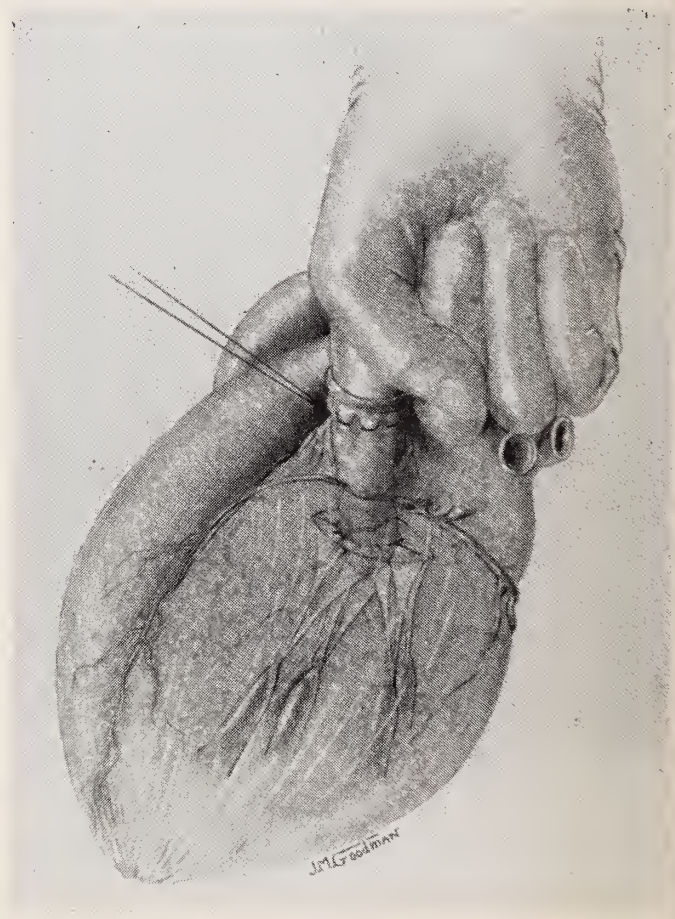


Figure 2. Drawing showing technique of mitral commissurotomy. If adherent anterolateral commissure cannot be separated with index finger, it is incised with valvulotomy knife inserted with finger.

affliction, it is also more difficult to correct. It has been much more difficult to make the incompetent valve competent than it has been to make the stenosed valve patent. While several techniques have been utilized experimentally and clinically for the

correction of mitral insufficiency, the most satisfactory has been that developed by Davila and Glover.^{12,13} This technique, based upon sound anatomic and physiologic principles, is directed toward diminution of the enlarged mitral ring sufficiently to permit approximation of the leaflet margins. This is accomplished by placement of a purse string suture around the mitral ring just beneath the coronary vessels. We have used a similar technique in the laboratory for the experimental creation of mitral stenosis.¹⁴ While some patients apparently have been improved, technical problems associated with placement of the suture render the technique far from satisfactory. Suturing of the annulus under direct vision utilizing a pump oxygenator gives promise of significant progress in management of this problem.¹¹

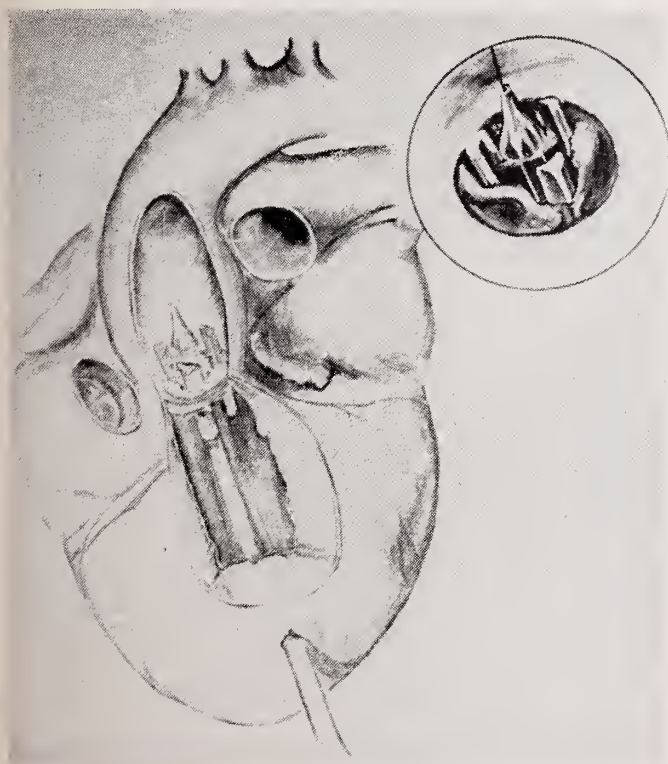


Figure 3. Drawing showing technique of transventricular aortic valvulotomy. The stenotic aortic orifice is dilated with valvulotome inserted through wall of left ventricle.

Surgery of the aortic valve has not developed as rapidly or as satisfactorily as that of the mitral valve. Identification of the fused aortic commissures and separation in the proper plane is much more difficult than in the case of the mitral valve and development of serious insufficiency has been a constant hazard. By means of transventricular valvulotomy¹⁵ (Figure 3) stenosis of the valve can be relieved, but the hazards of arrhythmias and uncontrolled bleeding from the left ventricular wound are great. By the transaortic approach¹⁵ and utilizing an artificial appendage (Figure 4), the incidence

of arrhythmia is less but relief of stenosis and preservation of valvular competency has not been entirely satisfactory. It has seemed to us that obstruction could be better relieved by means of the transventricular route.

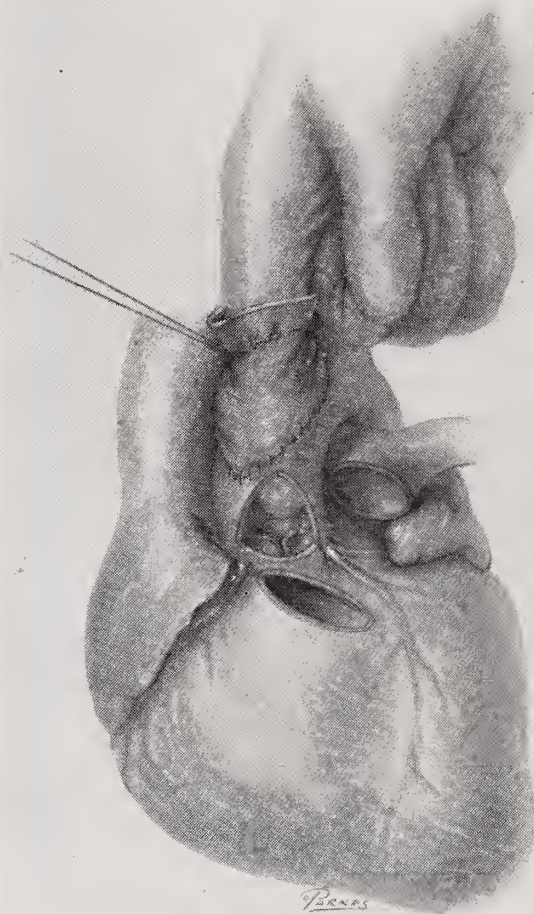


Figure 4. Drawing showing technique of transaortic valvulotomy. The valve is dilated with finger or dilator inserted through an artificial appendage sutured to ascending aorta.

A direct approach to these lesions became possible with development of the technique of hypothermia. By this means Lewis¹⁶ and Swan¹⁷ have performed aortic valvulotomy under direct vision, the fused commissures being incised in such a manner as to preserve function of the valve. Because of potential complications from the use of hypothermia, one is hurried because of having to limit inflow occlusion to five or eight minutes. Although worthwhile results can be obtained with this method, the dangers of serious arrhythmia and difficulties of restoration to sinus rhythm under hypothermia plus the disadvantages of the necessity of performing delicate surgery hurriedly have encouraged others in the use of exposure of the aortic valve during cardiopulmonary by-pass with a pump oxygenator^{11,18} (Figure 5). Under conditions of hypothermia the myocardium is protected against ischemia by the reduced metabolic requirement. During cardiopulmonary by-pass, however, one may minimize

the risk of myocardial ischemia by utilizing elective cardiac arrest with potassium citrate or acetylcholine or by retrograde perfusion of the coronary arteries. The best method remains to be determined.

During the past two years we have been studying the open approach to the aortic valve during cardio-pulmonary by-pass in the laboratory. At first a bubble-type oxygenator with Sigmamotor pump was used. Elective cardiac arrest was utilized, induced by potassium citrate, and with the low blood flows that were used (less than 50 cc/Kg body weight) the incidence of cardiac resuscitation after arrest was low. More recently total blood flows equivalent to 75 per cent to 100 per cent cardiac output have been obtained with a screen oxygenator (Mark Co.) and DeBakey pump. Under these circumstances restoration of cardiac function is more easily accomplished. With high blood flows, however, precautions are necessary to protect the pulmonary bed against pulmonary edema as a result of collateral blood flow to the lungs. This protection is accomplished by left atrial decompression with a catheter indwelling in the atrial appendage by means of which blood is returned to the pump oxygenator system with gentle suction.**

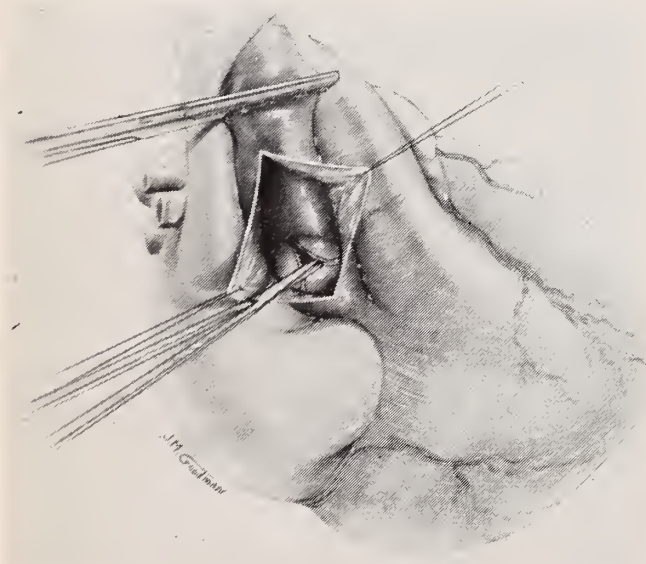


Figure 5. Drawing of direct exposure of aortic valve using hypothermia or pump oxygenator.

Aortic insufficiency, likewise, is a very serious disease in comparison with disease of the mitral valve. These patients get along remarkably well for many years, but in the course of time begin to deteriorate. Shortness of breath, syncope and angina are predominant complaints. Not infrequently sudden death occurs as a result of ventricular fibrillation. The development of a plastic prosthetic valve by

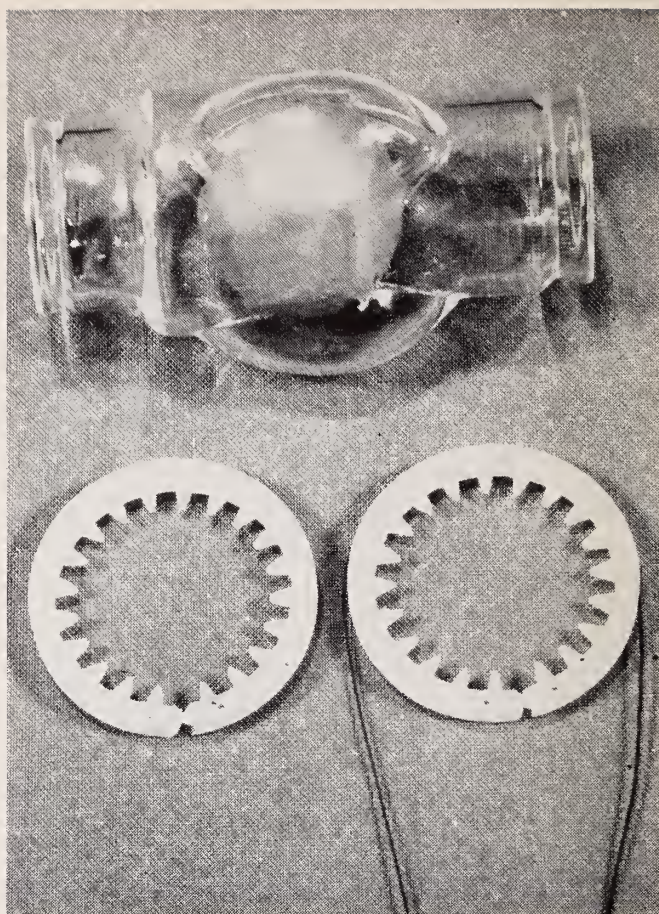


Figure 6. Photograph of Hufnagel valve, showing multiple point fixation nylon rings.

Hufnagel¹⁹ and its insertion first in 1952 represented great progress and many patients have been improved by this procedure. The one-way plastic ball valve (Figure 6) fastened into the upper descending thoracic aorta by an ingenious multiple point fixation technique, eliminates regurgitation of 75 per cent of the cardiac output (Figure 7). The utilization of

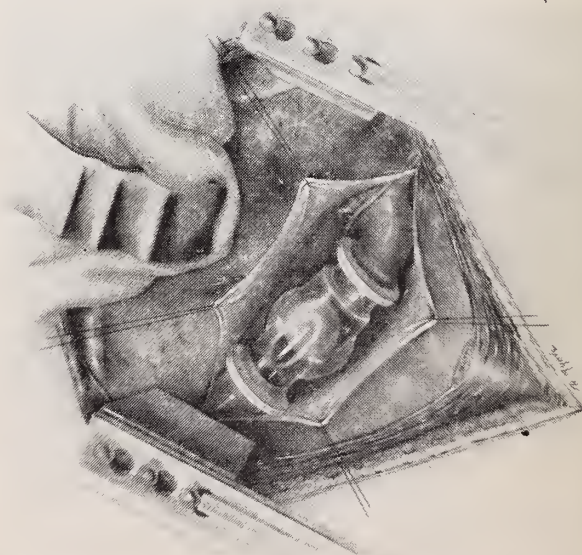


Figure 7. Drawing showing Hufnagel valve placed in upper descending thoracic aorta.

this valve has been said to be a physiologic gamble in that it reduces the work load of the left ventricle while at the same time it decreases coronary flow as a result of reduction in quantity and forcefulness of the regurgitating stream of blood. If the work load of the left ventricle is reduced out of proportion to the reduction in coronary flow, function of the left ventricle improves. On the other hand, if coronary flow is reduced more, as is more likely to occur in aortic insufficiency, myocardial deterioration may follow. Post-operative embolization apparently has been a universal complication and occasional reports of false aneurysms have appeared in the literature.²⁰ While this procedure is a very formidable one, its usage has represented an important contribution to the management of this disease. There is little doubt that in the course of time open exposure of the aortic valve with the pump oxygenator will make possible the placement of a prosthetic subcoronary valve. This is currently being investigated in several laboratories, including our own. * * Experimentally a single flap type seems the most encouraging. A two or three cusp valve moulded from plastic material or one constructed from the patient's own tissues offers great promise of providing a suitable prosthesis. Open exposure of the aortic valve area and fixation of a prosthetic valve in a subcoronary position are problems that remain to be solved. In some cases it is quite likely that plastic procedures upon the aortic valve will correct serious degrees of insufficiency without the necessity of inserting a prosthesis.¹¹

Congenital stenosis of the pulmonary valve is fairly common and produces marked right ventricular hypertrophy. These patients usually are not cyanotic unless there is an associated atrial septal defect allowing reversal of the shunt to occur. While an estimate of right ventricular pressure can be made from the electrocardiogram, an accurate assessment of the hemodynamics as provided by cardiac catheterization is helpful in planning a surgical attack. In the past, patients were accepted for surgery if right ventricular pressures exceeded 100 mm. Hg. With increasing experience in the management of this defect patients with pressures as low as 75 mm. Hg. have commonly been accepted. Surgical correction of pulmonary stenosis was first accomplished by Brock²¹ in 1948. The transventricular valvulotomy was performed by passage of a valvulotome and dilator through the hypertrophied right ventricular wall (Figure 8). By this means many patients have been relieved of symptoms. It soon became obvious to many groups, however, that right ventricular pressures often did not return to normal, although a marked reduction in pressure usually occurred. With the application of the open

technique utilizing inflow occlusion and hypothermia more satisfactory relief of obstruction can be obtained.²²

Currently our efforts are directed toward utilization of the pump oxygenator in view of the handicap of limited working time with hypothermia and the fact that occasionally infundibular stenosis or an atrial septal defect coexists and requires correction. Under direct vision the fused commissures are incised or the valve is converted into a bicuspid one by incising on each side down to the pulmonary annulus (Figure 9). Sometimes the valve is so rigid that the tip has to be excised to provide proper relief of stenosis. Under these circumstances insufficiency of the valve may occur. Physiologic studies four years after experimental total pulmonary valvectomy have demonstrated gradually enlarging hearts and progressive decrease in cardiac output, although clinically the dogs are doing well. While such marked insufficiency obviously is undesirable, because of the low pressure system minor degrees of pulmonary valvular insufficiency apparently are well tolerated.²³

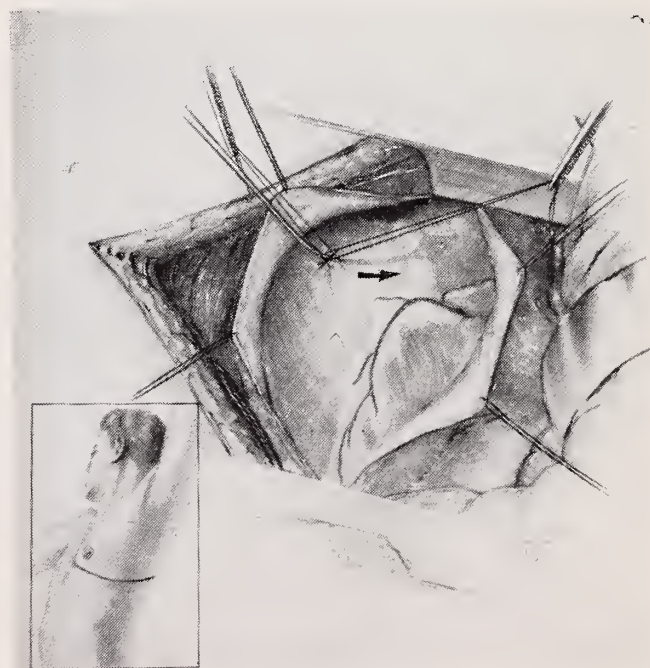


Figure 8. Drawing showing transventricular pulmonary valvulotomy.

An understanding of the types of atrial septal defect is necessary from the viewpoint of prognosis and from the viewpoint of repair. Ostium secundum defects usually do not produce serious symptoms until adulthood and from a technical standpoint are easier to repair than ostium primum defects because of the presence of an inferior margin of septal wall. On the other hand, ostium primum defects usually produce symptoms in childhood because of the larger shunts and associated

mitral insufficiency. From a surgical standpoint these defects are more difficult to repair because of their location and the associated involvement of the atrio-ventricular ring. For these reasons it is important to differentiate between them clinically prior to surgical exploration. Analysis of a small group of patients with ostium primum defects has been of considerable help in establishing this diagnosis.²⁴

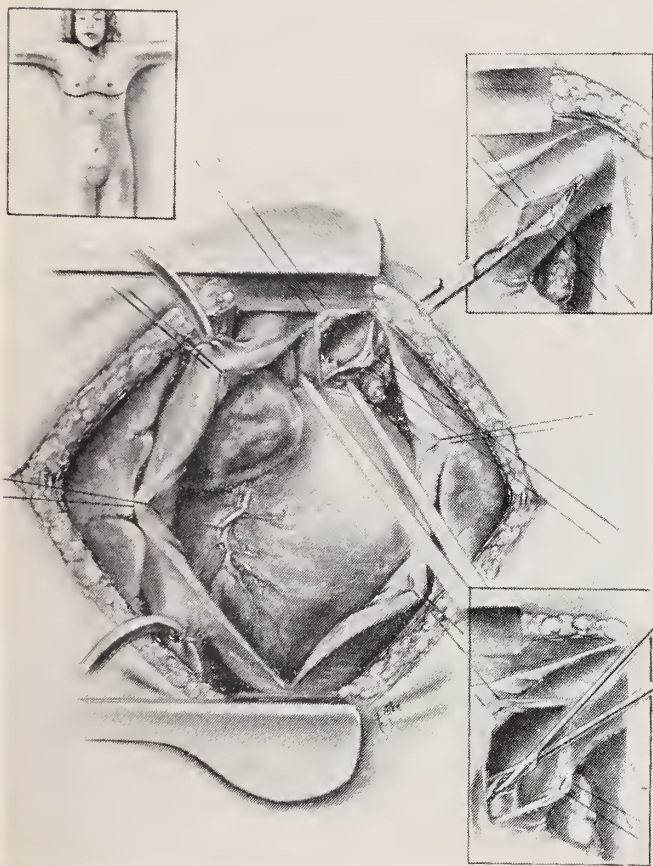


Figure 9. Drawing showing pulmonary valvulotomy under direct vision by means of hypothermia or pump oxygenator.

One of the first successful methods of closure of secundum defects was described by Gross.²⁵ This technique consists of utilization of a rubber auricular well sutured to the wall of the dilated right atrium in such a manner as to convert the right atrium and the well into one chamber. By working through the well the defect can be palpated and repaired by direct placement of sutures under the surface of blood (Figure 10). This semiclosed technique has been used with a reasonable degree of success in many cases. The technique of atrio-septopexy, described by Bailey,²⁶ consists of invagination of the redundant right atrial wall which is sutured to the margins of the defect. This method or modifications of it, can be successfully applied to many small defects, particularly if located high and/or



Figure 10. Drawing showing semi-closed technique of repair of atrial septal defect with rubber atrial well.

posteriorly. In 1953 Sondergaard²⁷ demonstrated that by mobilizing the right pulmonary veins from the right atrium a plane could be developed well down between the two atria and in the presence of a septal defect the inter-atrial groove could be developed almost to the defect. Also, he demonstrated that a probe can be advanced within the atrial septum just above the atrio-ventricular ring and the defect obliterated by an encircling suture tied within the interatrial groove (Figure 11). We have pre-

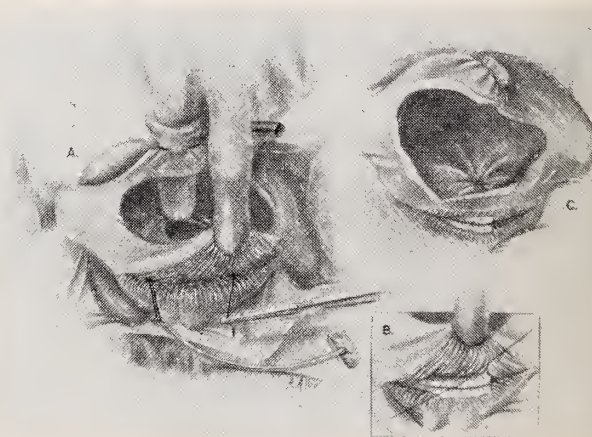


Figure 11. Drawing showing circumclulsion technique of repairing atrial septal defect.

ferred a modification of this technique²⁸ since often the probe penetrates the septal wall and enters one of the atria; reinforcing sutures placed with a double pointed Lam needle, usually can be easily placed with complete closure of the defect (Figure 12). With this method morbidity is minimal and mortality is equivalent to that associated with division of a patent ductus arteriosus.

Because of occasional incomplete closure of secundum defects by closed technique and the occasional presence of unexpected anomalies which can-

not be managed satisfactorily by closed methods, development of open techniques has seemed desirable. Since 1953 Lewis²⁹ and Swan³⁰ have utilized hypothermia with inflow occlusion for the open repair of secundum defects (Figure 13). This technique represented great progress but handicaps the surgeon because of the time limitation associated with hypothermia and because of the dangers of arrhythmias. For these reasons open repair by means of cardiopulmonary by-pass with a pump oxygenator seems a more desirable method. By using the pump oxygenator a more leisurely and meticulous closure can be accomplished and if a serious cardiac arrhythmia occurs the circulation can be supported until adequate cardiac function is resumed.

It is now recognized that ventricular septal defects are very serious anomalies. This is evidenced by the fact that few adults but a fair number of children are seen with these defects. Although the development of pulmonary hypertension in these individuals is usually quite insidious, serious pulmonary hypertension may suddenly progress within a few months. It has been demonstrated by Lillehei,³² Kirklin,³³ and others that if the pulmonary artery pressure exceeds 70 per cent of the systemic pressure the surgical mortality is high. On the other hand, repair of these defects by open technique in the presence of slight to moderate pulmonary hypertension, can be accomplished without excessive mortality.

The ventricular septal defect, because of its inaccessibility, has been one of the most difficult intra-

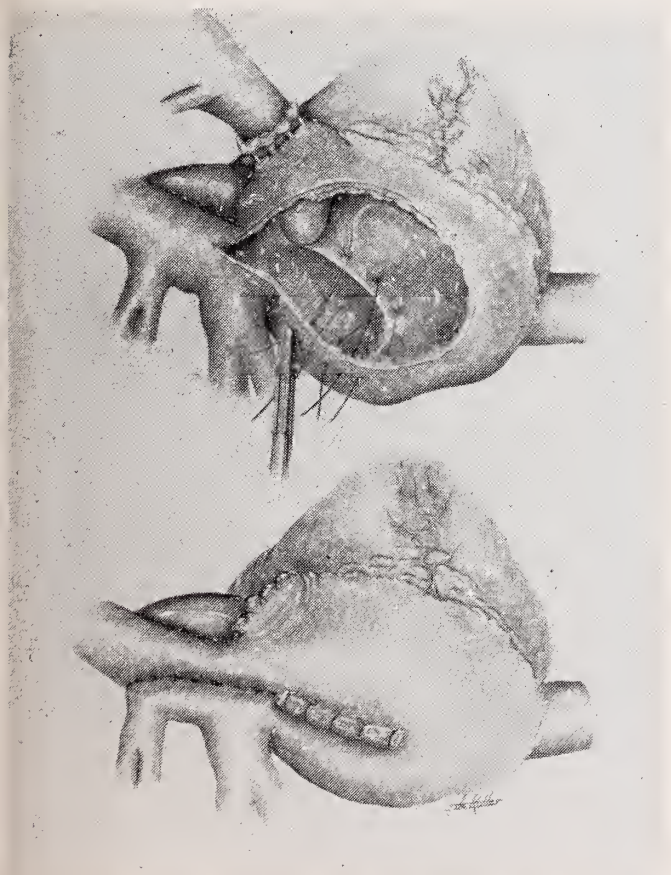


Figure 12. Drawing showing use of Lam double pointed needle for closure of atrial septal defect with interrupted mattress sutures. In this case partial anomalous venous drainage of the right lung was corrected by conversion of the superior vena cava into two channels.

Repair of ostium primum defects is feasible only by open technique using a pump oxygenator. Because of the location of the defect and the often associated cleft in the mitral valve, more time is needed for repair than can be safely obtained with hypothermia. These defects are best repaired by direct suturing of the cleft in the mitral valve and by suturing a compressed Ivalon sponge patch in the septal defect³¹ through a right atriotomy.

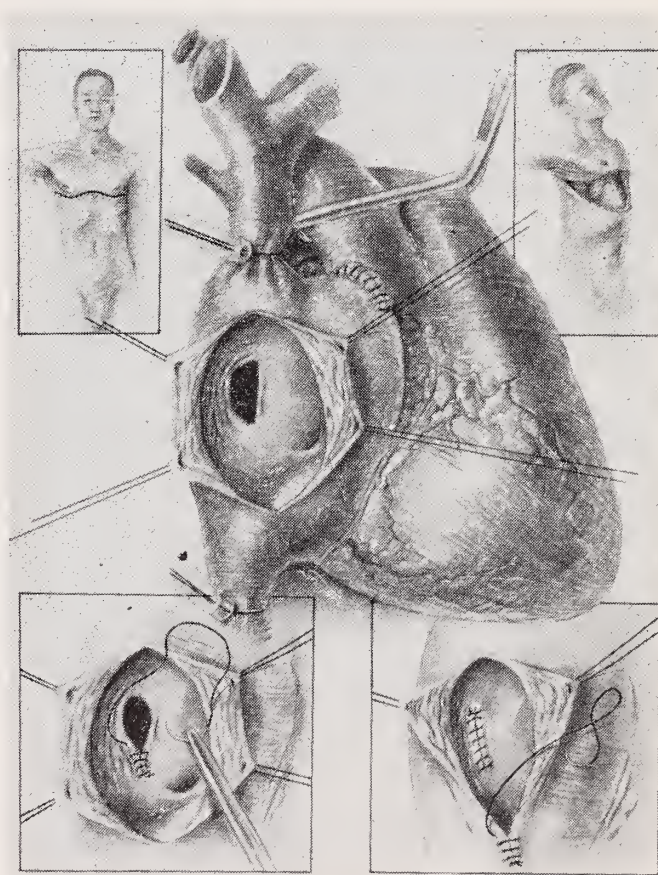


Figure 13. Drawing showing open exposure of atrial septal defect by hypothermia or pump oxygenator.

cardiac lesions to repair. Hypothermia proved to be inadequate because of increased irritability of the cold heart. It was not until the technique of cross circulation was developed by Warden, Lillehei, and others³⁴ that this defect was first successfully repaired in 1954. Since the utilization of the bubble oxygenator in 1955 by Lillehei and his group³⁵ and shortly thereafter the use of the Modified Gibbon (screen) oxygenator by the Mayo Clinic group,³⁶ ventricular septal defects have been repaired with

increasing frequency. Most of these defects are located high in the ventricular septum and the smaller ones (2-3 cms. diameter) can be satisfactorily closed by direct suture. The larger ones and those located down behind the medial cusp of the tricuspid valve can be better repaired by patching with compressed Ivalon sponge (Figure 14). While the surgical indications are not as yet clearly defined, in general, patients with slight to moderate pulmonary hypertension should have the defects corrected. Those with severe pulmonary hypertension and those with normal pulmonary pressures should be individualized. In all probability surgery will be recommended for most patients with normal pressures in the near future. Those with severe pulmonary hypertension present a most difficult problem. The vast amount of current investigation in this area will, it is hoped, lead to safer methods of managing this problem.



Figure 14. Drawing showing open repair of ventricular septal defect.

The tetralogy of Fallot, one of the more complicated types of defects, has been managed quite successfully since 1944 by some type of systemic-pulmonary artery shunt.⁴ This type of operation is palliative and actually does nothing to correct the basic problem. In many instances, symptoms recur as the children become older. Since the advent of open heart surgery with pump oxygenators, there has been a philosophy that surgery should be deferred unless required by the severity of symptoms. Increasing experience with pump oxygenators has encouraged the corrective type of surgery, i. e. repair of the ventricular defect and the relief of the infundibular or valvular stenosis. This is being done in more and more medical centers.

All patients with major cardiac defects, valvular

and septal, as well as the more complicated anomalies, such as anomalous venous drainage and transposition of the great vessels, may become, at some time in the future, candidates for the pump oxygenator.

Summary

A brief historical development of the technical approach to intracardiac lesions has been presented. While a conservative attitude is expressed in regards to the open approach to mitral stenosis, an aggressive attitude toward direct exposure of all other defects seems justified.

1116 Kirk Place

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THE USE OF ACTH AND STEROIDS IN THE TREATMENT OF ULCERATIVE COLITIS AND REGIONAL ENTERITIS

Spalding Schroder, M.D., *Atlanta*

Perforations or hemorrhages seem to be related to the severity of the disease process rather than to the therapeutic agents employed.

IDIOPATHIC ULCERATIVE COLITIS and regional enteritis are clinically and pathologically distinct diseases¹ which rarely coexist in the same patient but which have so much in common that they are said by Crohn² to "constitute diseases if not identical in nature, at least of the same family." They are both diseases of unknown cause; both occur in young people, as a rule, with isolated case reports if onset is in the elderly;³ both have an even sex distribution; many pages have been written regarding psychosomatic factors in both diseases; both are characterized by clinical remissions and exacerbations to varying degrees; and the pathological changes in both diseases are more often stationary or progressive than they are regressive. Only a minority of patients with either disease can be expected to become permanently asymptomatic; and there are very few claims for complete anatomical restoration to normalcy. A similarity of these two diseases to rheumatic fever and rheumatoid arthritis is the finding of arthralgias and erythema nodosum⁴ and has suggested the theory of collagen disease etiology.⁵ It was this same similarity to rheumatic fever and rheumatoid arthritis which provided a scientific basis for the therapeutic application of ACTH, Cortisone,[®] and related compounds.⁶

Although remissions in both diseases are frequently spontaneous, an impressive array of evidence has accumulated in the past ten years to support the thesis that remissions are capable of being induced by the use of ACTH or adrenal steroid therapy.

Insufficient time has elapsed to justify claims that permanent remission can be effected by this therapy but some of the results obtained offer more hope than any previously used treatment short of extensive surgery. Kirsner et al.⁷ reported on the treatment of 180 patients with ulcerative colitis with ACTH or steroids and noted an immediate beneficial effect in 85 per cent of the patients, although symptoms recurred in 70 per cent after omission of therapy. Repeated courses of cortico-therapy induced favorable responses in the majority of 91 patients re-treated, although the results were not as striking as in the first course. At the time of their report 113 patients were considered to be in complete or partial remission, not requiring continued steroid therapy. Thirty-nine of these have been in remission since the first course. The remainder have received multiple courses. Of their total group, 17 patients have undergone surgery, 12 have died (including one of the surgical group), and four have been lost to follow-up.

Similarly good results with ACTH and steroids in the treatment of regional enteritis have been observed by Machella,⁸ Kirsner, Palmer, and Klotz,⁹ and Yarnis, Marshak, and Crohn.¹⁰

The following case reports are presented to demonstrate some of our own experiences in the use of these compounds.

Case One

D. M. was a 28 year old housewife referred on May 31, 1951 complaining of bloody diarrhea with abdominal cramps. A diagnosis of amebiasis had been entertained by the referring physician but she

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had not responded to amebicidal therapy. Proctoscopic examination revealed a diffusely friable rectal mucosa which bled wherever the proctoscope touched mucosa. Rectal swabs and stool examinations were negative for ameba. Stool cultures were negative for pathogens. She was treated with Cortisone® for two weeks and her symptoms subsided. One year later her symptoms returned and again responded within a few days after beginning Cortisone® therapy. She remained asymptomatic for three years when she again had a mild recurrence which subsided after the self-administration of Cortisone® for one week. Two years later she had a recurrence and proctoscopic examination revealed findings identical to those seen six years previously. Rectal biopsy revealed changes of idiopathic ulcerative colitis. She is now in remission.

This patient's course is rather typical of the majority we have treated in that the symptomatic response to steroid therapy is so frequently dramatic. It has not usually been necessary to maintain patients on steroids longer than two months at a time. The expected recurrences, however, usually occur after varying intervals of time, just as one would expect in a disease whose natural history is so regularly punctuated by exacerbations. When this occurs retreatment is indicated. It has been our definite impression, however, that these recurrences are interrupted far quicker than when the disease runs its natural course and steroid therapy is not employed. It is to be hoped that the complications of stricture formation, polyposis, and carcinoma will be reduced significantly by the earlier remissions resulting from steroid therapy. It is highly desirable to avoid chronic invalidism or total colectomy whenever possible, and steroids seem to help accomplish these ends.

The next three cases are quite at variance with our usual experience but are reported to illustrate the interesting features presented by each of them.

Case Two

M. S., a 40 year old man, was referred in March, 1953 because of intermittent diarrhea. The original onset had occurred two years previously, six months after an episode of bleeding peptic ulcer. He had diarrhea without gross bleeding from his rectum for one month and was treated with antibiotics only. He remained free of diarrhea for 16 months at which time diarrhea recurred for one month and then subsided. His third recurrence was four months later, and it lasted for about one month, also subsiding spontaneously. He had no gross blood in his stools with those three episodes. His fourth bout began in January, 1953 with moderately severe bloody diarrhea, malaise, weight loss, and low grade fever. Proctoscopy revealed a diffusely hyperemic

and finely granular mucosa with pin-point ulcerations and increased friability, involving the entire 14 cms. of the rectum examined. Rectal smears and stool examinations for ameba and cultures were negative. Barium enema revealed involvement of the distal $\frac{3}{4}$ of the colon with typical changes of ulcerative colitis. The first few days of his hospitalization were characterized by chills, fever, and rectal bleeding. It was feared that this episode might represent an acute fulminating course and surgical consultation was requested. He was treated with intravenous ACTH and antibiotics and he made a rapid symptomatic improvement, with subsidence of all diarrhea in four days. Proctoscopic examination six months later revealed only minimal abnormality, and on subsequent examination two years after his hospitalization proctoscopic examination revealed normal rectal mucosa. Residual findings have persisted on barium enema although there has been distinct improvement during his follow-up studies. He has been followed closely for five years with mild recurrences of peptic ulcer activity but with no further clinical bouts of ulcerative colitis.

This case demonstrates the co-existence of peptic ulcer and ulcerative colitis. It is very interesting that he has continued to have recurrences of peptic ulcer activity with bleeding during the past five years while his ulcerative colitis has remained completely inactive both clinically and proctoscopically. This patient was seriously considered a potential candidate for colectomy on the basis of acute fulminating colitis. We feel quite safe in ascribing his dramatic improvement to the administration of ACTH.

Development of peptic ulcer during steroid therapy has been a subject of much speculation and appears to deserve constant consideration in patients receiving such therapy. The newer steroids are said to have fewer complications of this type.¹¹ On the other hand, Sklar, Kirsner, and Palmer¹² state: "the apparent development of a peptic ulcer during steroid therapy is unusual in our experience" having occurred in "only one such instance in a series of 180 patients with ulcerative colitis treated with ACTH or steroids."

Case Three

T. P. was 34 years old when referred on January 16, 1951 because of severe rectal bleeding with shock. He had been diagnosed 10 years previously during a three month episode of bloody diarrhea. He remained comparatively symptom-free for six months with no therapy but then had a return of symptoms for a few months. This was followed by three years of freedom from symptoms until one month prior to his admission. Because of persistent massive bleeding after admission, an emergency left hemicolectomy and colostomy was performed, after

ULCERATIVE COLITIS / Schroder

which he was placed on Cortisone® to diminish chances of further bleeding. He received 100 mgs. of Cortisone® intramuscularly every six hours for five days. It was felt that he was improving until the fifth post-operative day when his colostomy dressings were heavily saturated with blood and clots. He rapidly deteriorated, showing evidences of massive bleeding through the colostomy and it was decided that removal of the remaining colon was his only hope of survival. The operative note reads, "a hopeless situation was encountered. Brown fecal material was noted throughout the peritoneal cavity. The entire right colon was gangrenous and a large 8 to 10 cm. hole was found in the cecum. Another perforation was found in the transverse colon. The areas of perforation were drained and the abdomen closed." It was a surprise to all who observed him that he survived. He has subsequently had total colectomy and partial resection of his ileum and is now in excellent health. His brother has also required colectomy for the same disease.

This was the first patient with ulcerative colitis in whom we used adrenal steroid therapy and has been the only case of perforation encountered in our experience. The occurrence of perforation of the colon received considerable attention in the earlier literature¹³⁻¹⁶ and these reports have made many clinicians fear the use of steroids. We have felt this has deprived many patients of the benefits of these agents. The experience of Sklar, Kirsner, and Palmer¹² is cited in the following quotation: "in our experience, now approximating 200 patients, perforation has been observed in only two cases; in one instance the perforation was thought to have preceded corticotropin therapy." These authors add "giant ulceration and massive hemorrhages have been observed to respond favorably to corticoids. These complications thus seem to be related to the severity of the disease process rather than to the therapeutic agents employed."

Case Four

B. G. was a 26 year old housewife who was referred to us in February, 1957 with a history of recurrent bloody diarrhea for one year, 20 pound weight loss, and anemia that had required three recent transfusions. She was two months pregnant. The terminal rectal mucosa was the site of marked hyperemia, edema, and multiple bleeding points as viewed with an anoscope. Hospitalization was refused. She had an initial very satisfactory response to ACTH with normal stools for the first two months of therapy. She then relapsed and had moderately severe bloody diarrhea throughout the remainder of her pregnancy in spite of continued Acthargel®

and Meticorten®. She delivered a normal seven pound fourteen ounce baby girl on September 8, 1957, seven months after institution of therapy. After delivery her ulcerative colitis became much more severe and blood loss marked, requiring numerous transfusions and very large doses of ACTH and Meticorten® to the point of very pronounced Cushingoid appearance. A colectomy was performed on January 26, 1958. There was uniform involvement from cecum to rectum. When seen April 11, 1958 her ileostomy was functioning quite well and she was progressing satisfactorily.

This case illustrates the refractoriness of some patients to large doses of ACTH and steroids and the need for colectomy because of persistent and massive blood loss. The temporary remission that resulted initially during the third and fourth months of the pregnancy was difficult to evaluate in view of the beneficial effects of pregnancy reported in this disease. Felsen and Wolarsky¹⁷ observed definite amelioration of ulcerative colitis in 58 per cent of 43 pregnancies. This case also raises the question of how long is surgery to be postponed in patients who fail to respond to non-surgical measures. It is difficult to set a time-limit and, of course, each case must be judged by its own merits, but it is clear that there should be no delay if there is massive hemorrhage or acute fulminating colitis that does not respond to steroids. Fortunately, these are in the minority. The intractable patient with chronic invalidism who fails to respond to steroid therapy after a few months treatment with increasing doses should also have surgery, since they are infinitely more inconvenienced by invalidism than by a permanent ileostomy.

Case Five

A 23 year old male, A.A.W. was referred in 1956 with a chief complaint of anemia and diarrhea. The onset of diarrhea had been in 1948 which increased up to 20 non-bloody, watery stools daily. He also experienced four rectal abscesses and an anal fistula which were treated surgically. He had rather mild cramping R. L. Q. pains. The diagnosis of regional enteritis was eventually confirmed by radiologic studies, and one year after the onset of his disease two feet of terminal ileum together with the ascending colon were resected and ileotransverse colostomy was performed. Over the next several years there was a continuing problem of medical management involving chiefly his nutrition. About a year after surgery he had episodes of severe diarrhea and weight loss alternating with periods of improvement. A second operation was necessary in March, 1953 because of acute intestinal obstruction and a shunt operation was performed. Two months later 16 inches of small intestine were removed and the

shunt was taken down. In August, 1953 he noticed the appearance of one to two cupfuls of bright red blood with each stool. Proctoscopy revealed changes of ulcerative colitis and he received frequent blood transfusions and other supportive therapy with only temporary benefit. He was then treated with ACTH and Cortisone® for a period of three to four weeks with dramatic improvement which was sustained for two years. In early 1956 he began to lose blood again and his hemoglobin dropped to 7.8 grams per 100 cc. His stools averaged 5 to 20 a day during the six months before he was referred to us. His admission hemoglobin was 9.0 grams. Proctoscopic examination revealed a moderate amount of blood on the rectal wall which was descending from above, since the rectal mucosa had a normal appearance when this blood was removed. Barium enema revealed inflammatory mucosal changes at the ileocolostomy consistent with regional enteritis. He was placed on Prednisone® orally and received iron intravenously for two months because oral iron had regularly aggravated his diarrhea. Within two weeks his diarrhea decreased to two to four stools nightly. His hemoglobin rapidly returned to normal and has remained so for one year without requiring further intravenous iron. He continued to take Prednisone® for one year during which his diarrhea was significantly less than previous to therapy. He omitted Prednisone® nine months ago and did not have a relapse to eight to ten watery stools until two months ago. If this persists, steroid therapy will be resumed.

This case is presented in such detail because it illustrates the following points: (1) Recurrences following surgery are so frequent that resection for regional enteritis is now recommended only for obstruction or fistula formation. (2) Although steroid therapy did not result in complete cessation of diarrhea, it was followed by marked improvement. (3) Chronic blood loss anemia has been corrected and has remained corrected. (4) No ill effects resulted in the administration of Prednisone® for over a year. (5) Should relapses occur after omission of steroid therapy, retreatment should be given. (6) The ulcerative colitis accompanying regional enteritis (Ileocolitis) is quite amenable to steroid therapy and can be expected to subside completely in a much higher percentage of cases than (primary) idiopathic ulcerative colitis.

Summary

Idiopathic ulcerative colitis and regional enteritis are separate disease entities characterized by remissions and exacerbations that occur spontaneously but which may be induced more rapidly by the administration of ACTH and/or Adrenal corticosteroids. Five case reports are presented for

the purpose of illustrating various features of these two diseases in relation to this form of treatment.

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No significant differences were noted in the time of subsidence of signs and symptoms of thrombophlebitis between the control and study groups.

A CLINICAL EVALUATION OF INTRAMUSCULAR TRYPSIN IN THE TREATMENT OF ACUTE THROMBOPHLEBITIS

THROUGHOUT ALL FACETS of current medical and surgical practice, the incidence of thrombophlebitis is increasing. While this increase is seen primarily in the fifty to eighty age group commensurate with the increasing longevity of our population, it has also occurred in the younger decades. This is attributed not only to the alertness of physicians in detecting this disease, but also to the more frequent use of intravenous alimentation and blood transfusions through venous channels of the lower extremities. Byrne reports that an increase of 2.6 per one thousand in the number of admissions for thrombophlebitis occurred during the years 1943 to 1951.¹³

While progress has been made both in the prevention and management of this disease, there remains no unanimity of opinion regarding its management. Lumbar sympathetic block for the relief of vasospasm, anticoagulant therapy to prevent propagation of venous thrombi, antibiotics to halt infection, and ligational therapy to interrupt venous channels and prevent propagation of the disease with dislodgement of venous thrombi, are all measures of established merit in the management of thrombophlebitis. No single therapeutic agent or combination of agents, however, has yielded uniformly satisfactory results.

Concurrent with recent advances in the field of enzymology, the hypothesis regarding the action of trypsin* administered intramuscularly in inflammatory states interested and stimulated us to evaluate

William A. Reid, M.D. and

Albert H. Wilkinson, Jr., M.D., *Atlanta*

this agent in a group of carefully selected patients with acute thrombophlebitis.

Clinical Data

One hundred patients with acute thrombophlebitis were selected for study. All patients on the wards of Grady Memorial Hospital during a two year period from 1954 through 1956 in whom the diagnosis of thrombophlebitis was considered were examined by the authors. Since the usual manifestations of the disease are easily and often obfuscated by accompanying leg ulcers, cellulitis, and arthritis in an extremity, the cases included for study were only those who displayed acute thrombophlebitis. For comparison, a control group of patients was managed with anticoagulant therapy consisting of 50 mgm. of heparin given intravenously every four hours until a therapeutic range of dicumarol between 20 and 30 per cent of normal was achieved. The study group received no anticoagulants, but received intramuscular trypsin every eight hours in dosage of 2.5 mg. (0.5 cc) deep in alternating gluteal regions. Both groups of patients received penicillin and streptomycin during the febrile phase and were restricted to rest in bed without elevation of the lower extremities or application of compression bandages. Patients were placed alternately in the control and study group. All patients were evaluated daily and were ambulated 24 hours after signs and symptoms had abated. Patients were discharged

From the Whitehead Department of Surgery, Emory University School of Medicine, and the Grady Memorial Hospital, Atlanta, Georgia.

*Intramuscular trypsin (Parezyme®) supplied by National Drug Company.

the following day, provided that symptoms did not recur.

According to the severity of findings, patients were grouped as mild, moderate, and severe. (Table I). The following findings served as criteria: resting calf pain, pain on dorsiflexion of the foot, edema, heat, erythema, fever, tachycardia, and progression of the thrombosis. Age of the patients varied from three months to 85 years with an average of 46 years. There were 41 male and 59 female patients distributed among 38 white and 62 Negro patients.

Table I
Severity of Thrombophlebitis in Control and Study Groups

SEVERITY OF CLINICAL FEATURES	Number of Patients	
	Anticoagulant Group	Trypsin Group
1. Mild	21	26
2. Moderate	19	15
3. Severe	10	9
TOTAL	50	50

Since intravenous trypsin administered in large doses has been shown in dogs to promote intravascular thrombosis and in man has been attendant with severe and often grave anaphylactoid reactions, its use has been discontinued.¹² Intramuscular trypsin administered in small doses has been shown to be free from these untoward effects.³ The antiphlogistic action of small doses of trypsin given intramuscularly is attributed to the splitting of certain macromolecules which are present in areas of inflammation. These macromolecules impede the resorption of edema fluid and natural progress of the defense mechanisms provided by the body in response to inflammation.¹⁴

In the study group who received intramuscular trypsin, no untoward reactions were noted other than mild discomfort at the site of injection. There appeared to be no effect upon wound healing in post-operative patients. There were two patients who had non-fatal pulmonary infarctions and one patient who developed a fatal pulmonary infarction. In the fatal case, infarction occurred on the sixth post-operative day in a 45 year old white male who had received a shotgun blast to the lower abdomen with extensive damage to the iliac veins, urinary bladder, bony pelvis, sigmoid colon, and rectum.

In the group that received anticoagulant therapy, it was necessary to discontinue treatment in eight patients because of bleeding tendencies manifested by epitaxis, hematuria, or melena.

The clinical responses estimated in respect to the criteria of evaluation are summarized in Table II. While the patients who received trypsin became pain free on the average in 2.9 days less than those who received anticoagulant therapy and became completely asymptomatic in 2.1 days less, the differences are small and not of statistical significance. The average hospital stay of 4.3 days less in the study group is influenced to a considerable extent by the fact that all patients in the control group were hospitalized and received anticoagulants for an arbitrary minimum of 11 days, even if they became asymptomatic prior to the eleventh day.

In this study no follow up has been made with attempt to correlate recurrence and development of the post-phlebitis syndrome with the mode of therapy.

Table II
Incidence in Control and Study Groups of Principal Clinical Criteria for Evaluating Thrombophlebitis

	DAYS	
	Anticoagulant Group	Trypsin Group
1. Average time before significant improvement in pain . . .	3.5	3.4
2. Average time before complete relief of pain	11	8.4
3. Average time before local fever subsided	6	5.4
4. Average time before significant improvement in swelling . .	3.9	3.8
5. Average time before improvement in Homan's Sign	3.9	3.4
6. Average time before negative Homan's Sign	6.7	5.5
7. Average time before asymptomatic	11.6	9.5
8. Average period of hospitalization*	15.3	11

Summary

1. A clinical study of intramuscular trypsin in the treatment of acute thrombophlebitis is presented. One hundred patients are included comprising the study and control groups.
2. No untoward local or systemic manifestations following administration of trypsin intramuscularly were noted other than the occasional occurrence of mild discomfort at the site of injection.
3. No significant differences were noted in the time of subsidence of signs and symptoms of thrombophlebitis between the control and study groups.

INTRAMUSCULAR TRYPSIN / Reid

4. In the group treated with the intramuscular trypsin three patients, or six per cent, developed pulmonary infarction. One patient died as a result of the infarction.

5. Continued clinical study by careful control is essential to the proper evaluation of intramuscular trypsin in the treatment of thrombophlebitis.

340 Boulevard. N. E.

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WORK ROLE SEEN FOR HEART VICTIM

THERE IS A PLACE for those with heart disease in industry, said Joseph L. Block, president of Inland Steel Company.

Mr. Block told a meeting that unions must cooperate, however.

If union attitudes on seniority, assignments, health programs, and pensions were "too rigid," the employer is discouraged from hiring the handicapped, he said.

Union pressure on the administration of workmen's compensation laws also militates against a liberal employment policy in this field, Mr. Block explained. Such pressure overburdens employers with claims arising from the onset or aggravation of heart trouble.

He also called for closer cooperation among management, labor, and the medical profession and those governmental agencies concerned with health. The key to employment of people with heart disease, he said, was the pre-hiring physical examination followed by periodic examinations. This makes possible work assignments that will safeguard the employee's future welfare, Mr. Block said.

Inland, he added, has been able to employ a "great many" people with heart conditions as well as those suffering other handicaps.

Mr. Block was speaking at a meeting sponsored by the Chicago Association of Commerce and Industry, of which he is president, and the Chicago Heart Association.

In another report, two hospital executives wrote in the magazine, *Hospitals*, that hospitals themselves could solve personnel shortages by employing the handicapped and the elderly.

The executives were Dr. J. A. Rosenkrantz, administrator of the Albert Einstein Medical Center (Southern Division) in Philadelphia, and Dr. Pascal F. Lucchesi, executive vice president and medical director of the center. The American Hospital Association publishes the magazine.

They said that as rehabilitation programs became more effective, state and federal support had made it possible for more handicapped to go to work.

Hospitals, they urged, should set a good example by employing the aged and handicapped.

—The New York Times

PARENTERAL METHYLPHENIDATE HCL (RITALIN) IN BARBITURATE POISONING

Donald G. Rosenberg, M.D., William C. Rape, M.D., and

Lester Rumble, Jr., M.D., *Atlanta*

The toxic manifestations of barbiturate overdosage with depression of the cortical, midbrain, and spinal regions are now fairly common knowledge to those of the medical profession.¹ Treatment with lavage, stimulants, artificial respiratory apparatus, and the general supportive measures has been quite satisfactory in the mild to moderate cases. However, in severe overdosage attended by shock, coma, and respiratory depression, standard therapy has not been entirely satisfactory. Recently, a new pharmaceutical agent, methylphenidate hydrochloride (Ritalin®) has been introduced as a central nervous system stimulant.² Its mechanism and site of action are as yet not definitely understood. The following is a preliminary report of three cases of moderate and severe barbiturate poisoning treated with parenteral methylphenidate.

Case One

A 13 year old white female ingested an estimated forty 50 mgm. tablets (total 2000 mgm.) of Talbual.® She was found at approximately 7:30 A.M. deeply asleep and unable to be awakened. A physician saw her at that time and administered 7½ gr. of caffeine i.m. and transferred her immediately to the hospital. On arrival her pulse was 120, respiration 34, and blood pressure was 110/76. The patient was unconscious; pupils were dilated; pupillary and corneal reflexes were absent, as were the deep tendon reflexes. There was no evidence of head trauma. Salivation was persistent, and moist ronchi were heard throughout both lung fields. There was no

cardiac abnormality other than the tachycardia. The skin was moderately cyanotic.

An endotracheal tube was inserted and the secretions were cleared from the mouth and throat. She moved with extreme stimulation and resisted endotracheal intubation to a slight degree. The stomach was lavaged with normal saline. She was placed in a cold humidity oxygen tent, and intravenous five per cent glucose in distilled water was begun at 11:00 A.M. The blood pressure began to fall and the pulse rate increased. The patient no longer responded to any stimulation. At this time, methylphenidate was administered in the following dosage schedule:

4/4/57 at 11:00 A.M.	50 mgm. I.V.
12:20 A.M.	50 mgm. I.V.
11:45 A.M.	50 mgm. I.V.
12:00 noon	50 mgm. I.V.
12:20 P.M.	100 mgm. I.V.

Following the initial dose of methylphenidate the patient was noted to swallow, the pupils reacted to light, and the patella and ankle reflexes returned. A sustained ankle clonus was also noted. Within 15 to 20 minutes following the administration of methylphenidate these reflexes could no longer be obtained. This series of events was observed with each rapidly administered dose. It was then decided that a constant infusion might serve to maintain reflex activity. At 12:30 P.M. 200 mgm. of methylphenidate in 500 cc. of five per cent glucose in distilled water was begun. At 2:00 P.M. another 300 mgm. of Ritalin® was added to an I.V. solution, and at this time the blood pressure stabilized at 140/90, the pulse at 120, and respiration at 32. In addition, a single injection of methylphenidate was given at

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PARENTAL METHYLPHENIDATE / Rosenberg

2:55 P.M. with no apparent effect. At 4:15 P.M. 500 mgm. of methylphenidate was once more administered by I.V. infusion. At 4:45 P.M. the patient began to cough and move about in response to endotracheal suction, and toward the end of the infusion spontaneous movements of the limbs were noted. The methylphenidate was then discontinued. Approximately eight hours later activity was somewhat lessened, and methylphenidate was restarted at 8:55 A.M. in doses of 20 mgm., 15 minutes apart. Ten such doses were administered (I.V.) from 9:00 A.M. to 12:00 noon. During this time gradual awakening was noted. The endotracheal tube was removed at 11:45 A.M. on 4/5/57, and the patient gagged and coughed when suctioned. At 3:10 P.M., the patient opened her eyes, responded when spoken to, took sips of water, and tried to talk. From this point, progress was rapid, the patient complaining only of a "sore throat," and she was discharged on 4/6/57.

A total dose of 1600 mgm. of methylphenidate was administered over this 36 hour period. Urinary output was good throughout the procedure, and catheterization was frequently required due to bladder distention. At no time did the blood pressure rise more than 30 mm. of Hg. above the admission level, and there was no alteration of pulse rate.

Case Two

Case two was a 74 year old white female with a history of cerebrovascular accident in 1951 with residual left hemiplegia. She had documented hypertension of four years duration and had been on digitalis. In November, 1957 she fell, sustaining a fracture of her left hip. This was nailed with uneventful recovery, and she was discharged on 11/19/57. On that evening she noted recurrence of the hip pain which persisted until 2:00 A.M. on 11/20/57 at which time she ingested 22 Nembutal® capsules (gr. 1 ss), a total of 32 grains. She was found in a comatose state the following morning and was brought to the Emergency Clinic. No emesis was noted by the family or attending physician.

Physical examination: Blood pressure 100/50 (previous pressure one week prior was 210/90), pulse 72, respiration 18. She was comatose and unresponsive to all stimuli. Her pupils were miotic and did not react to light. She had no corneal or gag reflexes. The deep tendon reflexes were hyperactive and a Hoffman's sign was present on the left. There was some spasticity of the left side. The plantar response was flexor bilaterally. Her lungs were clear but her respirations were slow and shallow. The

neck was supple, heart and abdomen negative.

Three ampules of coramine (1.5 cc.) and one ampule of caffeine (1 cc.) were administered intravenously without effect. A lumbar puncture revealed initial pressure of 88 and final pressure of 50. The fluid was clear and contained one lymphocyte. An EKG showed some subendocardial injury. (Urine: non-contributory except for many WBC's and granular casts; hematocrit 34, WBC 11,700 with 52 segs, 40 lymphs. Blood sugar 248; BUN 26; C1 90.0; Na 125; K 5.2).

She had not had and did not receive gastric lavage. Approximately one and one half hours after admission she was given 50 mgm. of methylphenidate I.V., and 100 mgm. of methylphenidate were begun in 1000 cc. of glucose in water. Her blood pressure remained 104/50, pulse 80, and respiration 20. Two and one half hours after admission she was given 30 mgm. of Wyamine® with no effect on the blood pressure. These vital signs remained unchanged for six hours, when another 100 mgm. of methylphenidate in 100 cc. of glucose in water was added. Seven and one half hours after admission her blood pressure rose to 130/60, pulse 84, and respiration 24. These fluctuated for the next 12 hours at which time another clysis with 100 mgm. of methylphenidate was added. Clinically she remained totally unresponsive. Approximately 24 hours after admission her blood pressure was 170/78, pulse 112, respiration 28, and another clysis of 100 mgm. of methylphenidate had been given. She was noted to move her head and left arm at this time. Because of secretion, a tracheotomy was performed. Her condition remained stable, and no further methylphenidate was given. On 11/23/57 at 10:15 A.M. (72 hours after admission) she opened her eyes and "blinked" when told to do so. Return of motion in all extremities was noted over the next 24 hour period, and clinical improvement was dramatic. She has continued to do well without complications. A total of 450 mgm. of methylphenidate was used in the initial therapy.

Case Three

Case three was a 30 year old white female who had been followed by a local physician for two years for a possible collagen disease. On the day of admission, she "became depressed" and ingested an unknown quantity of gr. 3 Amytal® capsules (originally had 12). When seen at her physician's office he found her blood pressure 90/70, respiration 0-2 per minute, no response to painful stimuli, and no pupillary reflexes. Deep tendon reflexes were present. She was given three ampules of caffeine sodium benzoate (1.5 cc.) and two ampules of Coramine® (1.5 cc.) intravenously. Blood pressure rose to 100/60, respirations to 10 per minute, but

TABLE I

	Respirations per minute	Pulse	Blood Pressure	Medication
4:00 P.M.	9	64	100/70	100 mgm. methylphenidate I.V.
4:20 P.M.	14	80	110/70	150 mgm. methylphenidate I.V. in 1000 cc. G/W
5:00 P.M.	8	80	112/70	
5:20 P.M.	9	80	100/70	
6:05 P.M.	10	82	104/82	100 mgm. methylphenidate I.V. in 1000 cc. G/W
6:25 P.M.	10	88	100/70	
7:20 P.M.	12	92	108/70	
7:45 P.M.	14	100	110/70	
8:15 P.M.	15	100	105/75	
8:45 P.M.	17	100	110/75	
6:00 A.M.	18	94	110/75	

the patient remained unresponsive. She was then transferred to the emergency ward. On arrival her blood pressure was 95/78, respirations 3, no response to painful stimuli, and absent corneal and pupillary reflexes. Deep tendon reflexes were absent.

The patient was given 100 mgm. of methylphenidate I.V. at 3:20 P.M. Table I shows the observations and medications noted during the next 18 hours.

The patient became more restless and responsive and was transferred to another institution at 9:30 A.M. the following morning. At this time pupillary, corneal, and deep tendon reflexes were present, and the patient was conversing with her husband.

Summary and Conclusions

A preliminary report of the use of methylphenidate in three cases of barbiturate intoxication has been presented. On the basis of these observations

it would appear that methylphenidate is effective. The apparent initial effect of methylphenidate was to maintain respiration and blood pressure without significant alteration of the level of consciousness. Our assumption at present is that the primary action of the drug may be at a medullary level. Further studies are now in progress.

Addendum

Since this article was prepared for publication, a report of the use of methylphenidate in barbiturate intoxication has appeared in *Neurology* (8:267, April, 1958) by Ticktin et al which further corroborates the indication for the use of this drug in this clinical entity.

Grady Memorial Hospital

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1959 ATLANTA GRADUATE MEDICAL ASSEMBLY DATES SET

PLANS HAVE BEEN COMPLETED for the largest and most complete Atlanta Graduate Medical Assembly in the 17-year history of this most popular Dixie Medical Meeting.

The dates have been set for February 16, 17, and 18, 1959 at the Convention Hall of the Atlanta Biltmore Hotel.

An exceptionally comprehensive speaking faculty has been selected this year offering the widest variety of medical specialty topics ranging from Allergy to Nuclear Medicine. Each speaker is a recognized leader in his field and each has made

prominent and recent contributions to the profession for which he has received wide acclaim.

A most popular feature of the Atlanta Graduate Medical Assemblies of recent years has been the scheduling of "Luncheon Conferences" and small afternoon "Roundtables" where attending doctors can get together informally in small groups with one or two of the visiting speakers and exchange questions and answers in an easy, relaxed "no holds barred" fashion. More of these popular luncheon conferences and roundtables have been added to this year's A.G.M.A. schedule in response to increased demand.

OXYGEN CONTROL POLICIES FOR PREMATURE INFANTS IN GEORGIA

Dorothy Jaeger-Lee, M.D., F.A.A.P., *Atlanta*

*A joint study of the Newborn Eye Care Committee of the Medical Association of Georgia
Maternal and Child Health Division of the Georgia Department of Public Health.*

RETROLENTAL FIBROPLASIA has been of prime concern to the Newborn Eye Care Committee of the Medical Association of Georgia and to the Georgia Department of Public Health because of its humanitarian and medicolegal aspects, and the fact that the development of this condition, except in rare instances, can be prevented by adequate oxygen control measures.

Studies conducted by A. Patz, L. E. Hoeck, and E. DeLaCruz from January, 1951, to May, 1953, incriminated high concentrations of oxygen as the causative factor in producing retrolental fibroplasia in young animals and premature infants. Since 1954 many studies of retrolental fibroplasia and oxygen administered to premature infants* have supported the original observation that excessive concentration of oxygen can produce retrolental fibroplasia. Studies also demonstrated the cumulative effect of prolonged exposures to higher concentrations of oxygen in very young animals and human subjects with immaturely developed retinas.

Each year, in spite of this knowledge, sporadic cases of retrolental fibroplasia are still occurring in Georgia. The Advisory Committee on Eye Care of the Newborn requested the Maternal and Child Health Division of the Georgia Department of Public Health to prepare and send a questionnaire on oxygen control to all hospitals in Georgia with

facilities for obstetrical patients to determine and evaluate the methods of control of oxygen administration to premature infants in the delivery rooms and nurseries.

Questionnaires were mailed to 198 hospitals licensed for the care of obstetrical patients by the Hospital Services Division of the Georgia Department of Public Health. Replies were received from 161 hospitals (81.3 per cent). This is a gratifyingly high percentage of completeness of reporting.

The questionnaire provided space for the hospital to indicate whether or not the report should be anonymous. Space designated for the name and location of the hospital was not filled in on only six of the returned questionnaires. This prevented us from knowing the number of bassinets in these six hospitals; therefore, they could not be included in the tabulation. Answers to the remainder of the questionnaires reflect the policies of hospitals in Georgia with 2167 bassinets or 88 per cent of all of the bassinets in hospitals in Georgia.

Table I shows hospitals queried regarding oxygen control policies for infants of five and one-half pounds or less, showing number and percentage of hospitals and bassinets reporting and not reporting, November, 1957:

Table I

HOSPITALS			BASSINETS	
	<i>Number</i>	<i>Percent</i>	<i>Number</i>	<i>Percent</i>
Total Queried	198	100.0	2463	100.0
Reporting	161	81.3	2167	88.0
Not Reporting	37	18.7	296*	12.0

*Includes bassinets in six anonymous hospitals listed as reporting.

From the Georgia Department of Public Health, Atlanta, Georgia.

**For the purpose of classification, a premature infant is a liveborn infant with a birth weight of five and one-half pounds or less, according to the definition now used in official national total statistics.*

Answers to the questionnaires were evaluated and tabulated according to the "Suggested Policy for Controlled Oxygen Administration for Premature Infants"**, this was developed jointly and distributed by the Medical Association of Georgia's Newborn Eye Care Committee and the Maternal and Child Health Division of the Georgia Department of Public Health.

The items related to "gauge on resuscitator" were intended by the originator of the questionnaire to indicate whether or not there was a gauge to limit the concentration of oxygen given the infant during resuscitation. From the questionnaire answers and review of resuscitators on the market, it became obvious that this item had a variety of meanings to the persons answering the questionnaire—such as, an "indicator of rate of oxygen flow," "the negative pressures used in suctioning the infant," "positive pressures for insufflation of the infant's lungs," and "pressure of oxygen in a cylinder." Therefore, the replies to this item do not give the information needed to evaluate the concentration of oxygen used during the resuscitation of a premature infant. Unless cylinders are premixed to deliver 40 per cent oxygen and 60 per cent nitrogen or a resuscitator is provided with a limiting device (and these are not in general use), the concentration of oxygen used during resuscitation is not controlled. The literature does not record how long an exposure during resuscitation to 100 per cent oxygen is needed to produce retinal changes in a premature infant. (It is known, however, that infants have developed retrolental fibroplasia who had oxygen concentration of only 40 per cent or less administered in their incubators, but who were resuscitated numerous times during their first week of life by a device which delivered 100 per cent oxygen.) Physicians who have had much experience resuscitating infants believe that, except in infants with pathological conditions, if the infant's airway is cleared of mucus and debris, additional oxygen is seldom needed for resuscitation. Frequently, however, immediately after delivery infants are "flushed out" with 100 per cent oxygen as a routine procedure.

Answers to the questions on oxygen administration in the delivery room showed that 15 hospitals (with a total of 396 bassinets) routinely give oxygen to all infants in the delivery room. Concentrations of oxygen greater than 40 per cent can be the means of saving the lives of hypoxic premature infants; however, competent clinical judgment is needed in such cases rather than routine procedures.

Table II shows hospitals reporting on oxygen control policies for infants of five and one-half pounds or less, showing number and percentage of

hospitals and bassinets by adequacy of policies, November, 1957.

Table II

ADEQUACY OF POLICIES IN THE NURSERY				
HOSPITALS		BASSINETS		
	Number	Percent	Number	Percent
TOTAL	161	100.0	2167	100.0
ADEQUATE	12	7.5	147	6.8
ADEQUATE EXCEPT FOR:				
Lack of Orders	26	16.1	492	22.7
No Limiting Device	4	2.5	285	13.2
Orders and No L. Device	3	1.0	152	7.0
Limiting Device	3	1.0	152	7.0
INADEQUATE (Uncontrolled)	116	72.0	1091	50.3

Twelve hospitals (147 bassinets) met all of the requirements for controlled oxygen administration. Six of these (84 bassinets) use premixed tanks of 40 per cent oxygen and 60 per cent nitrogen.

Four hospitals (285 bassinets) have adequate orders, measure and record oxygen concentration on the infants charts every eight hours, but do not use a limiting device to control oxygen flow into the incubator. This leaves a stray human element subject to error.

Twenty-six hospitals (492 bassinets) met all of the requirements except that adequate orders for oxygen administration were non-existent. It is felt by the committee that the premature infant's physician should have the responsibility of prescribing oxygen therapy in writing as needed for the individual, rather than its being a routine procedure or a standing order. Orders for oxygen therapy should be reviewed at 24-hour intervals and renewed only if necessary.

Three hospitals (152 bassinets) which do not have limiting devices nor require adequate orders for oxygen therapy measured the oxygen concentration with an oximeter and recorded the oxygen concentration on the infant's chart at least every eight hours.

This leaves 72 per cent of the hospitals or 50.3 per cent of the bassinets in the state with inadequate orders, no limiting devices, and no oximeters for measuring the oxygen concentration so that it may be recorded.

Table III shows the adequacy of orders in 20 hospitals reporting the use of premixed tanks of 40 per cent oxygen and 60 per cent nitrogen in the care of infants of five and one-half pounds or less. These were also included in the total tabulations of Table II.

Premixed tanks of 40 per cent oxygen and 60 per cent nitrogen have not been in widespread use. In connection with this study on oxygen control policies for premature infants in Georgia, experiments were performed to determine the liter flow necessary to obtain 40 per cent oxygen concentra-

OXYGEN CONTROL / Jaeger-Lee

tion in three of the most commonly used incubators using the 40-60 tank as a source of oxygen (these premixed tanks were furnished by the Southern Oxygen Company). It was found that the required liter flow for 40 per cent oxygen concentration in the incubator varies with the different types of incubators. Copies of this oxygen concentration study using premixed tanks are available on request to the Maternal and Child Health Division of the Georgia Department of Public Health.

Table III
Adequacy of Orders in Hospital Nurseries
Using Premixed Tanks
Written Orders Renewed Every 24 Hours

	Hospitals Number	Bassinets Number
Total	20	207
Adequate	6	84
Inadequate	14	123

Follow Up of Results of Study

Most of the hospitals indicated on the questionnaires that they wished a report of the findings of this study on Oxygen Control Policies for Premature Infants. Along with a copy of this report a letter will be sent to each hospital that cooperated (except for the six anonymous replies) indicating that adequacy of oxygen control measures effective in the hospital November, 1957, as evaluated in this report.

During the past year there has been a close working relationship between Hospital Services Division and Maternal and Child Health Division of the Georgia Department of Public Health. This has resulted in an increased awareness of the problem of premature care, and especially of oxygen control policies. Articles on oxygen control and its relationships to retrolental fibroplasia have been prepared for and published in *Hospital Notes*, which is a monthly publication of Hospital Services Division for hospitals in Georgia.

Within the past several months Hospital Services Division has included oxygen control measures and equipment as part of the check list for routine hospital newborn nursery inspections.

Summary

Questionnaires on oxygen control for infants weighing five and one-half pounds or less were mailed to all hospitals in Georgia licensed for the care of obstetrical patients. The answers given on

the questionnaires were evaluated according to the "Suggested Policy for Controlled Oxygen Administration for Premature Infants"*** which was developed by the Committee on Eye Care of the Newborn of the Medical Association of Georgia. This study revealed that 12 hospitals (6.8 per cent of bassinets in Georgia) have adequate oxygen control policies for premature infants; 33 hospitals (42 per cent of bassinets in Georgia) are measuring the oxygen concentration in incubators and recording this on the infant's chart at least every eight hours, but oxygen control policies are inadequate because of lack of a limiting device and/or requirement of a physician's written order and renewal orders every 24 hours for oxygen therapy; 116 hospitals (50.3 per cent of bassinets in Georgia) have neither adequate facilities or policies required for controlled oxygen administration for premature infants.

12 Capitol Square, S.W.

***SUGGESTED POLICY FOR CONTROLLED OXYGEN ADMINISTRATION FOR PREMATURE INFANTS

1. Oxygen should be administered to premature infants only on specific written order of a physician.
2. During the resuscitation of a premature infant, either in the delivery room or the nursery, oxygen should be administered in the lowest possible concentration and for the shortest time necessary to relieve the infant. Except in very rare cases, it is not necessary to exceed a concentration of 40 per cent. Routine control of this concentration can be accomplished with a premixed tank of oxygen 40 per cent and nitrogen 60 per cent, or by using a resuscitator designed for oxygen concentration control.
3. In the nursery oxygen should be administered in the lowest possible concentration necessary to relieve the infant, not exceeding 40 per cent unless it is absolutely necessary to increase the concentration as a life-saving measure. A higher concentration of oxygen should be available for those special instances where it is indicated, and given only on the written order of a physician. It should be discontinued as soon as the infant's condition permits.
4. The order for oxygen should be renewed every 24 hours by the physician in writing.
5. When oxygen is prescribed, and the premixed tanks of 40 per cent oxygen and 60 per cent nitrogen are not used, an oxygen limiting device should be on the incubator, the actual concentration of oxygen in the incubator should be checked with an oxygen analyzer frequently until the concentration has become stabilized and thereafter at least every eight hours. The oxygen concentration within the incubator and the time of reading should be recorded on the infant's record. (Nursing Notes)
6. A notation should be on the infant's chart when oxygen therapy is begun and terminated.

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AMA TO SPONSOR THREE MEDICOLEGAL MEETINGS

THE AMERICAN MEDICAL ASSOCIATION has announced that another series of three regional medicolegal conferences will be held next March and April as part of a continuing effort to create a better working relationship between lawyers and doctors.

Dates and locations for the conferences are: at the District of Columbia Medical Society headquarters, Washington, March 20-21; at the Hotel Cleveland, Cleveland, April 4-5; and at the Hotel Utah, Salt Lake City, April 18-19.

The three conferences, sponsored by the A.M.A. Law Division in cooperation with state and local medical societies, will draw doctors and lawyers from surrounding states. While most of the participants on each program will be from out of the state, local speakers will also appear. Between 250 and 400 persons are expected to register for each meeting.

The Washington session will draw doctors and lawyers from Maryland, Virginia, Delaware, West Virginia, New Jersey, Pennsylvania, New York, North Carolina, Connecticut, and Massachusetts.

The following states will be represented at the Cleveland meeting: Ohio, Michigan, Indiana, Wisconsin, Illinois, Kentucky, Tennessee, West Virginia, and Pennsylvania.

The Salt Lake City session will draw from Utah,

Colorado, Wyoming, New Mexico, Arizona, Nevada, California, Idaho, Oregon, and Washington.

While the program for each meeting will not be completed until after the first of the year, it has already been decided that the following subjects will be covered in speeches and question-and-answer periods: narcotic addiction, traumatic neurosis, *Res Ipsa Loquitur* and medical professional liability, contingent fees, and impartial medical testimony.

At each of the meetings the sessions will be presented for a half day on Friday and a full day on Saturday. Luncheons will be served each Saturday with no planned program on Friday night.

The registration fee for each conference will be \$5 to cover the cost of the luncheon and a copy of the proceedings. Advance registrations should be mailed to the Law Division, American Medical Association, 585 North Dearborn Street, Chicago 10.

C. Joseph Stetler, director of the A.M.A. Law Division, said that 1959 marks the third time that meetings of this type have been sponsored. He said that they have accomplished much in creating a better understanding between the medical and legal professions.

"Medicine and the law must work together so frequently that we feel open discussions of mutual problems are imperative," he said.

Close cooperation between the surgeon and the radiation therapist is essential in the effective treatment of tumors in this area.

CARCINOMA OF THE LARYNX

John F. Dillion, M.D., *Augusta*

IN RECENT YEARS, radiation therapists have been prominent in calling attention to the necessity for accurate anatomic diagnoses in squamous cell lesions involving the oropharynx and the laryngopharynx. Lederman, Baclesse, Nielsen, and Harris have written in the past decade important publications on the nature and treatment of these tumors.

It is a commonly held misconception that all of the lesions in the laryngopharynx are essentially the same and that their treatment should be the same with slight modifications. It is not infrequent that physician will label a lesion in the "throat" or in the "larynx" when actually a more specific anatomic diagnosis could be given.

Accuracy in determining the site of origin is not merely an academic pursuit, since accurate diagnosis is essential in the choice of treatment.

This discussion will treat only of lesions in the larynx. Carcinomas of the base of the tongue, of the valleculae, of the glosso-epiglottic fold, of the pharyngo-epiglottic fold, of the ary-epiglottic fold, of the piriform sinus, of the posterior wall of the hypopharynx, and of the cervical esophagus will not be included.

An accurate anatomic diagnosis of carcinoma of the larynx can be made in most patients. Indirect laryngoscopy should be performed first. Following this, a direct laryngoscopy with biopsy is indicated. A radiographic study of the larynx can be performed. This usually includes a lateral soft tissue radiograph of the neck and tomography of the larynx. These two latter procedures can give much information concerning invasion of cartilage and subglottic extension. This information is difficult to obtain in any other way.

In the tomographic study of the larynx, a coronal body section is visualized. In an adequate study, the false cords, the ventricles of Morgagni, the true cords, and the subglottic region are demonstrated.

Baclesse has called attention to a very interesting clinical fact. Supraglottic cancers (vestibule and ventricular cavity) do not extend in the larynx below the level of the true vocal cord. Subglottic cancers may grow upward but not beyond the true vocal cord. Glottic cancers and cancers of the ventricle of Morgagni may grow upward and downward. These facts are useful in determining the exact site of origin and also are useful in selecting treatment.

The specific sites of origin of tumors of the supraglottic portion of the larynx are as follows (Baclesse):

1. Cancers of the tip of the epiglottis.
2. Cancers of the laryngeal surface of the epiglottis.
3. Cancers of the false cord.
4. Cancers of the posterior-inferior aspect of the vestibule.
5. Cancers of the superior-lateral aspect of the vestibule.
6. Cancers of the ventricle of Morgagni.

Approximately 55 per cent of all squamous carcinomas of the larynx occur in the true cords. Approximately 40 per cent of the squamous carcinomas of the larynx involve the supraglottic region. Subglottic cancers comprise approximately five per cent of these tumors. The most frequent site of origin within the supraglottic region is in the false cord, with ventricular tumors second in incidence, and cancers of the laryngeal surface of the epiglottis third.

Lenz has emphasized the importance of the lymphatic network within the larynx. There is a rich

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lymphatic network in the region of the ventricle, in the region of the posterior aspect of the larynx and in the region of the superior lateral aspect of the larynx. Baclesse lists the frequency of nodal metastases from the following sites or origin:

Laryngeal surface of the epiglottis, 31 per cent.

Anterior commissure, 10 per cent.

False cord, 30 per cent.

Ventricle of Morgagni, 33 per cent.

Superior lateral aspect of the vestibule, 75 per cent.

Posterior-inferior aspect of the vestibule, 71 per cent.

True vocal cord, 4 per cent.

There are several factors to be considered in the choice of treatment of squamous cell carcinomas of the larynx.

1. The site of origin of the tumor.
2. The extent of the lesion.
3. The presence or absence of cervical lymph node involvement.
4. The gross character of the lesion.
5. The histo-pathologic appearance of the biopsy specimen.
6. The age and general condition of the patient.

The first three factors are of prime importance. The second three are of lesser importance. The site of origin is the most important factor. It gives a clue to the biologic nature and potentialities of the lesion. In determining the extent of the lesion, one considers the size of the lesion and the structures involved within the larynx. It is important to know whether mobility of the larynx is impaired or if cartilage has been invaded by the cancer. It is well known that exophytic and superficial tumors without impairment of function of the larynx can be controlled more readily by radiation therapy than those lesions in which there is infiltration and fixation of the structures within the larynx.

Lesions of the Epiglottis

Lesions of the epiglottis are usually divided into lesions of the tip of the epiglottis and lesions of the laryngeal surface of the epiglottis. These two lesions behave in distinctly different manners. The portion of the epiglottis above the level of the hyoid bone is considered to be the tip of the epiglottis. The portion of the epiglottis below the level of the hyoid bone is considered to be the laryngeal surface of the epiglottis. Cancers of the tip of the epiglottis are usually poorly differentiated. They present as exophytic masses which ulcerate and ultimately amputate the tip of the epiglottis. These lesions are frequently associated with large bilateral cervical lymph nodes. They are treated by the radiation therapist with two parallel lateral opposing fields. The primary lesion

in the tip of the epiglottis can be controlled frequently with external radiation. Control of the lymph nodes in the neck is a somewhat more difficult problem. When the neck nodes are treated by the radiation therapist they respond initially very well, but in the majority of cases the lymph nodes are not sterilized by the radiation therapy. The primary lesions in the tip of the epiglottis, although they involve cartilage, are usually not painful and can be controlled with radiation therapy.

Lesions of the laryngeal surface of the epiglottis extend anteriorly, penetrate the cartilage to invade the pre-epiglottic fat space. They may also extend superiorly to involve the valleculae. They may extend laterally to involve the ary-epiglottic fold. These lesions present nodes in approximately 30 per cent of cases. They can be cured with external radiation therapy provided the lesion is exophytic and does not involve the cartilage. Ulcerating, infected lesions involving the pre-epiglottic fat space, cannot be controlled by the radiation therapist.

Squamous cell carcinomas of the false cord are occasionally exophytic but most frequently are infiltrating. These lesions, characteristically, spread from the anterior portion of one false cord through the foot of the epiglottis to involve the false cord on the other side. This "saddle" appearance is classical. These lesions have also been described as lesions arising at the junction of the foot of the epiglottis and false cords. However, classically, these lesions are considered to be of false cord origin. Extensive lesions are prone to ulcerate and become infected. These lesions present lymph nodes in approximately 30 per cent of cases.

Carcinomas of the ventricle of Morgagni are especially difficult to control. Early lesions are difficult to diagnose. Very frequently one sees, on indirect laryngoscopy, only a slight elevation of the false cord or edema of the arytenoid region. Tomographic examination of the larynx occasionally shows an obliteration of the ventricle. They may grow into the false cord or down into the subglottic region. They may grow laterally where, after a short distance, they invade the ala of the thyroid cartilage. These lesions present nodes in about 30 per cent of cases. Patients with ventricular cancers have a poor prognosis. These lesions are extremely difficult to control by radiation. These lesions are best treated by a total laryngectomy followed by post-operative radiation therapy.

Lesions of the posterior inferior aspect of the vestibule are usually of the infiltrating ulcerating type. They may extend laterally to involve the thyroid cartilage. They may grow superiorly to involve the pyriform sinus and ary-epiglottic fold. These

lesions present nodes in approximately 70 per cent of cases. These lesions are best treated by a total laryngectomy. If operable nodes are present, a neck dissection should be done. The surgery should be followed by radiation therapy to the neck.

Lesions of the superior lateral aspect of the vestibule are usually voluminous exophytic lesions which involve the ary-epiglottic fold at an early stage. They may also extend into the vallecula. They may obliterate the pyriform sinus. Surgery and post-operative X-ray therapy are indicated if there are no significant lymph nodes or if lymph nodes are resectable.

Lesions of the anterior commissure are usually small and exophytic. They metastasize to lymph nodes in approximately 10 per cent of individuals. These lesions may be exophytic. Extensive lesions of this type involve the inferior margin of the thyroid cartilages. These lesions, when they are extensive, can penetrate the cartilage and present anteriorly in the skin of the neck. If metastases are present, the sentinel or delphian node is frequently involved. If there is no fixation to cartilage, and if metastases have not occurred, these lesions are well treated by external radiation therapy. If cartilage is involved or if significant nodes are present, surgery is the treatment of choice.

Lesions of the True Cord

Lesions of the true cord are usually well differentiated, superficial lesions. They may spread the entire length of the cord to involve the anterior commissure. Occasionally they traverse the anterior commissure to involve the anterior portion of the opposite cord. These lesions may grow into the ventricle superiorly and may descend inferiorly into the subglottic region. Nodes are present only infrequently. In those lesions without impairment of mobility, nodes are practically never present. In the extremely advanced cases, nodes are present in approximately four per cent of individuals. Exophytic lesions involving the true cord can be readily cured with radiation therapy. Even moderately advanced lesions of the cord with moderate impairment of mobility can be cured by radiation therapy. However, when these lesions are infiltrating and involve deeply the musculature, especially in the region of the vocal process, the prognosis with radiation therapy is not good. In advanced lesions with fixation of the vocal cord or with involvement of cartilage or extensive subglottic involvement, cure can almost never be obtained by the radiation therapist. If the radiation therapist treats these advanced lesions, he may be able to control the cancer. A prolonged period of painful necrosis will probably result. Even if radia-

tion therapy is successful in controlling the disease, surgery is frequently necessary to control the necrosis.

Subglottic Tumors

Subglottic tumors are rare. Occasionally they begin below the anterior commissure and grow to the level of the inferior surface of the true cords. These lesions present nodes in approximately ten per cent of cases. They are difficult to control with radiation therapy. Lesions of the subglottic region may originate on the lateral or posterior wall of the subglottic region. These lesions are in the domain of the surgeon. Lesions on the lateral wall of the subglottic region are probably best treated by surgery alone. Lesions on the anterior or posterior wall are perhaps best treated by surgery followed by post-operative radiation therapy to the neck.

Positive Indications for Surgery

The most successful treatment for cancers in the larynx requires the close collaboration of surgeon and radiation therapist. There are certain lesions within the larynx which the radiotherapist can scarcely hope to cure. There are certain other lesions within the larynx which the radiotherapist can cure without difficulty and without loss of function. There are several positive indications for surgery. They are as follows:

1. Invasion of the pre-epiglottic space.
2. Destruction of cartilage.
3. Complete fixation of the vocal cords.
4. Extensive subglottic extension of tumor.
5. Resectable lymph nodal metastasis.

There are several types of operation for the removal of malignant tumors of the larynx. They are as follows:

1. *Corpectomy.* This operation is suitable only for small lesions of the middle third of the true vocal cord. This operation should not be done for extensive superficial lesions of the vocal cord.

2. *Partial laryngectomy of the frontal type.* This operation is designed for extremely small lesions of the anterior commissure. This operation involves sacrificing portions of the thyroid cartilage. The functional result following this type of surgery is usually not imminently satisfactory.

3. *Partial laryngectomy of the fronto-lateral type.* This operation is suitable for small lesions of the anterior portion of one cord with extension into the anterior commissure. This operation leaves the patient with a voice which is audible but which is not entirely satisfactory.

4. *A total laryngectomy.* This operation is most commonly employed for extensive lesions of the larynx. It is indicated for most lesions of the supraglottic and subglottic region, as well as for most extensive glottic lesions. When this type of opera-

tion is performed, phonation is almost impossible. With total laryngectomy the patient is usually left without a satisfactory voice. The patient, however, may develop an esophageal voice. Electronic devices may be employed which may allow the patient to express himself.

In selecting surgery or radiation therapy or a combination of the two, one should be influenced primarily in attempting to save the life of the patient. A secondary, but by no means negligible, aim should be the preservation of speech. The optimum aim should be to save the life of the patient while preserving the maximum degree of function of phonation.

A recent publication by physicians of the Foundation Curie presents some interesting information. Separate radiation therapy services function at this institution. On one service, a combination of surgery and post-operative X-ray therapy was instituted for many types of laryngeal lesions. On the other service, practically all of the patients were treated with external roentgen therapy. In patients with supraglottic tumor, the five year survival rate for surgery and post-operative X-ray therapy was 48 per cent, while only 28 per cent of patients treated with X-ray therapy alone survived. In patients having lesions of the anterior commissure and mobile portions of the true cord, the cure rate for surgery and post-operative X-ray was essentially the same as that obtained for X-ray therapy only. For extensive squamous carcinomas of the true cord region, surgery and post-operative X-ray therapy was superior to X-ray therapy only. For subglottic lesions, too few cases were studied. No conclusions could be drawn. These figures, I believe, are significant since this study was performed in an institution which historically has been favorable to the point of view of the radiation therapist.

In summary, cancers of the larynx may be treated by surgery or radiation therapy or a combination of both. I believe that the opinion among radiation therapists, while not unanimous, suggests the following recommendations:

1. Extensive lesions of the tip of the epiglottis with invasion of the pharyngo-epiglottic fold or valleculae should probably be treated by surgical procedure followed by post-operative radiation therapy.
2. Supraglottic tumors can be cured more frequently by a combination of total laryngectomy followed by post-operative radiation therapy to the neck.
3. There is almost unanimity that squamous carcinomas of the ventricle of Morgagni should be

treated by total laryngectomy and post-operative radiation therapy to the neck.

4. Certain small exophytic, non-infiltrating, non-ulcerating lesions of the vestibule may be treated by radiation therapy alone, provided lymph node metastases are not present. These lesions can be cured by radiation therapy. The cure rate is inferior to that obtained by surgery. There is considerable additional risk to the life of the patient if radiation therapy is used. The procedure which offers the best chance for survival consists of a total laryngectomy with or without neck dissection, followed by post-operative radiation. Partial laryngectomies for supraglottic tumors are usually not satisfactory.

5. Lesions of the true vocal cord are probably best treated by radiation therapy alone. These lesions, unless they are extensive with invasion of cartilage and fixation, can be cured by the radiation therapist with great regularity.

6. Tumors of the anterior commissure can also be readily cured with radiation therapy alone.

7. Lesions of the posterior commissure should probably be treated by the surgeon.

Several recent articles list the five-year survival rate for tumors of the larynx. Jackson cured limited lesions by surgery in 87 per cent of cases. The more advanced lesions were cured in 64 per cent of cases. Harris, late radiation therapist to Mount Sinai Hospital, New York, cured early lesions in 72 per cent of cases. His survival rate for more advanced lesions was 67 per cent. Nielsen of Denmark, a radiation therapist, has a five-year survival rate for early lesions of 86 per cent of cases and for patients with more advanced disease, a survival rate of 48 per cent. Baclesse of the Foundation Curie has a cure rate of 45 per cent for early lesions and 24 per cent for more advanced lesions.

Three Major Technics

Three major technics are employed in treating cancers in the larynx:

1. The small field treatment for lesions of the glottis. These fields are approximately 5 x 5 cm. The lesions are treated with two lateral parallel fields. The patient is seen daily in the treatment position by the physician. Indirect laryngoscopy is performed daily by the radiation therapist. Accurate placement of the fields and accurate calculation of the tumor dose is necessary. With a 250 KV therapy, a tumor dose of 5,000r in four weeks is usually sufficient to control these glottic lesions. With this type of radiation therapy only a small volume of the neck is radiated. This treatment is successful in approximately 80 per cent of cases. Should the treatment be ineffective, a total laryngectomy can be performed with only slight increase in risk to the patient.

2. The second major type of treatment is post-operative radiation therapy to the neck. The entire neck from the mastoid tip to the clavicle is treated. The large fields include the wound and the anterior portion of the neck. This type of treatment is the best given with 200-250 KV apparatus. The upper neck fields are paralalled opposing. The lower neck fields are contiguous to the upper fields and cover the supraclavicular fossae. A small daily given dose is administered to each field with 125r skin dose being delivered to the upper fields daily and 100r to the lower neck fields daily. These fields are treated five days a week for a period of eight weeks. The purpose of this treatment is not to sterilize palpable disease. The aim is to prevent seeding in the wound following the surgery. If, at the time of surgery, resectable lymph nodes are present, they should be removed by a radical neck dissection.

3. The third major type of radiation therapy is large field palliative therapy.

The radiation therapist feels that his major contribution in the management of patients with cancer of the larynx consists in treating those patients having lesions of the mobile portion of the true vocal cords. He has great difficulty in controlling extensive vocal cord lesions and lesions of the supraglottic regions. The radiation therapist feels that he has a significant role to play in the control of true vocal

cord cancer. These cancers comprise 50 per cent of the lesions in the larynx. They cause symptoms early and they can be discovered early. They have a long natural history. They are not prone to give metastases. These lesions are readily cured by surgery or radiation therapy. Surgery offers a slightly better cure rate. Radiation therapy offers an extremely good cure rate with the added feature of conservation of laryngeal function. This type of treatment can be done without risk to the life of the patient. In the complex world of today, it is extremely worthwhile to attempt to save the function of phonation in as many individuals as possible.

Medical College of Georgia

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NEWLY LICENSED PHYSICIANS IN GEORGIA

<i>Name</i>	<i>Address</i>
Charles Allard	3151 Wiltshire Drive, Avondale Estates, Ga.
Michael Cardis	Buffalo Veterans Hospital, Buffalo, New York
Paul Arthur Cooper	Grady Memorial Hospital, Atlanta, Georgia
Carmen Cornejo	1777 Piedmont Ave., Apt. B3, Atlanta, Georgia
Themistocles John Diamandis	Duval Medical Center, Jacksonville, Florida
Frederick Cummins Hester, III	2665 B. Dauphinwood Drive, Mobile, Alabama
Walter Gostin Jarrell	Duval Medical Center, Jacksonville, Florida
Oswald Raymond Jensen	4625 Flecha Drive, Tucson, Arizona
Evert Erwin Kuester	119 Terrace Road, Spartanburg, S. C.
Theodore Levine	313 Clermont Avenue, East Point, Georgia
Jose Ramon Martinez	U. S. Naval Hospital, Portsmouth, Virginia
Herbert James Michals	Spartanburg General Hospital, Spartanburg, S. C.
William James Scheyer	6 Highland Drive, Savannah, Georgia
Fernando Luis Varela	2600 S.W. 37th Avenue, Miami, Florida

Note: Licenses issued by examination.

INFLUENCES OF THE FIRST FACULTY OF THE MEDICAL COLLEGE OF GEORGIA UPON THE AMERICAN MEDICAL CURRICULUM AND THE ORIGIN OF THE AMERICAN MEDICAL ASSOCIATION

Martin E. Blutinger, *Augusta*

*This paper represents the first
and only attempt to deal with this
chapter of medical history intensively.*

ON DECEMBER 20, 1828, the state legislature of Georgia, under the influence of the Medical Society of Augusta, passed an act "to establish and incorporate the Medical Academy of Georgia." Twenty-four physicians were appointed to draw up rules and regulations, select professors and instructors, and to meet annually with the appointed professors and teachers in order to examine and "decide on the merits of such candidates as may have studied in said institution at least one year . . . and to confer the degree of Bachelor of Medicine." The original plan was that the students would obtain the first course of instruction in the new Georgia school and the final second year course of lectures would be taken at the Medical College of South Carolina. After successful completion of the two courses of lectures, the latter school would confer upon them, as second course students, the degree of Doctor of Medicine. An inquiry as to the feasibility of this plan was sent to the Carolina faculty. The president of the South Carolina Medical Society replied, stating that the laws of his state's medical school could not make the desired arrangement until Georgia

should be nationally recognized as equal to the rest of the medical schools in the Union.

This blockage prompted the legislature to charter the trustees in May, 1830 with power to award the M.D. to satisfactory candidates who completed two terms of lectures "in addition to the usual term of private instruction (preceptorship) required by other institutions of like kind."

Article V of this charter read:

"The scholastic term shall be one year, and the lectures shall commence on the first Monday of October and end the third Monday of May following . . ."

Shafer¹ notes that for medical education the period from 1800 to 1830 was, generally, one which subscribed to the 13-week term, while reformers were crying out for a 14 or even a 16-week term of study.

The Georgia resolutions of 1830 came too late to be put into effect during the 1831-32 term, but in 1832, under its new name of the Medical College of Georgia, it commenced instruction as a radical six-month term school. Shafer observes that "Bowdoin required 13 weeks, two schools 14 weeks, two schools 15 weeks, nine schools 16 weeks, one school 18 weeks, the Medical School of the State of South Carolina 20 weeks . . ." He further states that the Medical College of Virginia had a nine-month term, however, the students attended only two lectures daily and one school year sufficed for the degree, whereas all the other schools required two terms, over a two-year period, for the medical doctorate.

The idea of the establishment of a medical school in Georgia was first conceived and successfully executed by Milton Antony, M.D. (1789-1839). At

¹Presented as the inaugural address of the Milton Antony Medical History Society of the Medical College of Georgia, Augusta, Georgia, Sunday, October 15, 1958.

Mr. Blutinger is a senior medical student at the Medical College of Georgia, Augusta, Georgia.

16 years of age he entered into a preceptorship in the office of a Doctor Joel Abbott of Monticello, Georgia. Three years later he went to the Medical School of the University of Pennsylvania, and after the first session, due to lack of funds, he returned without a degree. He set up practice in Monticello and worked industriously for seven years. He left Monticello in favor of New Orleans for a brief period, but soon returned to Augusta, Georgia. His absorbing personality, professional zeal, and initiative marked him as a leader among his contemporary Georgia physicians. In 1822 he organized the Medical Society of Augusta, and in 1825 he, with others, successfully petitioned the legislature to establish a State Board of Medical Examiners in Milledgeville, Georgia, then the capitol of the state. He was its first president.

In 1826 Doctor Antony and one of his pupils, Doctor Joseph Allen Eve, established a preceptorship arrangement for desirous students at the hospital in Augusta. The next year two other instructors were added to the staff. This eventually led to the establishment of the Medical Academy in 1828, as mentioned above. He held the chairs of Medicine, Diseases of Women and Children, and that of Midwifery.

Feeling the need for a journal of medicine geared especially for the southern physician and for his varied regional medical problems, Antony founded in 1836 the *Southern Medical and Surgical Journal* and was its editor until his courageous death as a ministering physician in the yellow fever epidemic of 1839.

From his vantage as professor, medical school founder, leader in southern medical politics, and most especially as the editor of the South's only medical journal, Milton Antony made known his desire for reform in licensure and medical education. His influences permeated all with whom he worked. His design was that his school would point the way to reform; it would offer the best in medical education. The lectures occupied six months, and two courses of lectures were required for graduation.

The trustees and faculty were convinced of the necessity of standardization and expanded curriculum, and as a new school, a child among elders, they made their proposal public in a circular letter, so prevalent a mode of communication in that day. It was addressed to every allopathic medical college in the country:²

Medical College of Georgia
May 19, 1835

"To the faculty of the
Medical College of, etc.:

"The Faculty of the Medical College of

Georgia would present to their fellow labourers in the cause of medical science a subject of great importance and of common interest.

"We believe it is a subject of regret . . . that the terms of admission into the profession are so easy; that young men do now present themselves . . . whose mental discipline disqualifies them to reap the advantages of our various institutions . . .

"Thoroughly convinced that (the medical profession), requires that the Medical Colleges of the United States, now, take some decided action upon this subject of medical education, we beg leave respectfully, to solicit your cooperation in effecting a convention of Representatives from the Medical Colleges, to be held at Washington, for the purpose of establishing a uniform system of requisitions for the degree of Doctor of Medicine; of regulating the courses . . . ; extent of previous education . . . and the means of rendering our institutions most successful in diffusing the benefits of medical education.

"We do not fix any time for holding this proposed convention; but in our communication to the University of Pennsylvania, have proposed May 1836 . . . the determination of the time, the number of delegates from each college, etc. should be referred to the Faculty of the University of Pennsylvania, the oldest medical school in our country.

"Should this suggestion meet with your approbation and concurrence, we shall ever rejoice in having contributed to a reformation, which, though it may operate peculiarly to the disadvantage of our own college, [Probably referring to the possibility of a national convention choosing a curriculum shorter than six months, already felt to be proper by Georgia.] will yet promote the interest of the common cause of medical science . . ."

(signed) L. D. Ford, Dean

Of course, this was not the first attempt prior to 1835 at reform through organization. In 1827 the Vermont and New Hampshire Medical Societies invited other New England organizations, as well as that of New York, to a conference on medical reform³ which was held in Northampton, Massachusetts.

The proposals set forth were:

- (1) To form a national society
- (2) Medicine to be studied three years after the acquisition of an A.B. degree (four years without degree)
- (3) Allow only a six weeks vacation from preceptorial study
- (4) Require one full term of courses
- (5) Require two full terms for the M.D.
- (6) Good moral character of students
- (7) Plan to be effected July 4, 1829⁴

Unfortunately, demands of the time and competition of non-participating medical schools caused the signers to shun the plan the same year in which it was to have begun. However, William Henry Welch⁵ states that Yale faithfully adhered to the principles for three years, but was forced to abandon them, their being too far advanced; the other northeastern schools considered them a deterrent to attracting students.

Doctor Ford's letter exceeded in scope similar previous proposals of American medical education reformers which were often vague and obscure. Here was truly a request for unification on a national scale, and every recognized institution was polled. Favorable replies began to be received. Outright refusals and those with no reply shaded the faculty's optimistic picture gray. Some held hope that this could be reversed by a favorable reply from Pennsylvania, for this school had not yet answered. In September, 1836, Joseph A. Eve, in reporting the situation to date stated:

"... (The results) afford an inauspicious augury for the cause of medicine in our country, and we are apprehensive that some time will elapse before the desired changes are achieved ... We are happy to learn by the address of Professor Wood to the graduates of the last commencement of the University of Pennsylvania, that it is proposed to extend the course of lectures in that institution to six months ..."⁶ (This did not come to pass for many years.)

Eve seemed to feel that this was a favorable sign of eventual approval of the Georgia plan by the most influential school in the country.

This hope was short lived, however, when six months after the posting of the circular, reply was received from Pennsylvania:

Philadelphia, Nov. 15, 1835

Dr. L. D. Ford, Dean

Dear Sir—

Shortly after the reception of yours of May 19th, I informed you of the fact and of my intention to lay your communication, on the subject of modifying the terms of admission into the Profession of Medicine, before the Medical Faculty at their first business meeting ... The Medical Faculty, after giving it full consideration, have thought it better for each school to adopt such regulations as might suit its particular views, than to enter into any general obligations on the subject, when there exists no competent power to prevent their violation.

I am, very respectfully, your ob't sev't,
W. E. Horner, Dean, etc.⁷

This coup d'grace swamped the young school's gigantic attempt at national unification and was to lead to an injustice that the college did not deserve.

Disappointment prevailed at Georgia, but the crusade did not wane, and Milton Antony, in particular, in his capacity as editor of the *Southern Medical and Surgical Journal*, promoted the cause at every opportunity.

In 1837⁸ he lauds the editor of the *Boston Medical and Surgical Journal* who in March 1837, haranged the apathy of his fellows in the establishment of a strong national society. Antony at this time re-outlined his plan:

"... the beginning point would be the establishment of associations in every state and territory. This done, a periodical channel of communication to every individual possessing one spark of professional zeal would at once spring into existence and be perpetrated, and individual societies would be established in every settlement where half a dozen practitioners could be found. And if journals should be found insufficient for communication between states, let the association be represented in annual convention after each meeting of state associations."

In 1838, after valiantly maintaining a six-month curriculum for five years, the board of trustees reduced the term to four months in order to conform with the other schools and to attract students who were attending institutions that offered the shorter course.

Antony, referring to the 1835 proposal:

"... (Doctor Ford's) proposition not being met by the other colleges, the Georgia College found it impossible to complete successfully with the popularity of a short, cheap course for students. If there be error therefore in adoption of four months ... the blame is fairly attributed to the retention of short courses by the (other) colleges."⁹

Turning his wrath upon the student, rather than the University of Pennsylvania to which he would have liked to have directed it, he concludes:

"... could the majority of medical students be allowed to sway the colleges in this particular, the term would soon be reduced to two or three months."

In June, 1830 a convention had been held in Washington for purposes of revising the *United States Pharmacopeia*, and at that meeting it was decided to meet again, for the same purpose, ten years later in January, 1840. In 1839 the medical society of the State of New York called for a national convention to be held in Philadelphia in May, 1840, under conditions similar to Georgia's proposal of 1835.

Antony was as jubilant at this new prospect as he had been morose the year previously, a mood swing characteristic of reformers who feel inspired with the justness of their cause.

"We are truly happy to perceive . . . that the attention of the medical profession is again called to the importance of a convention of its members . . ."

He recounts his school's failure, heartily wishes success to those who "now urge the call," and suggests the possibility of unification of the two meetings.¹¹

This, also, did not come to pass. Milton Antony died shortly thereafter and the journal which he spearheaded was discontinued for six years. These were inopportune years of silence for the medical conscience from the South, for the time was at last ripe. Nathan Smith Davis, M.D., the brilliant young reformer in New York, began during this period, 1840-1846, to campaign for active reform. As a responsible member of the New York State Medical Society, he was author of several proposals in education and licensure. Opposition within the New York ranks prompted Alden March, M.D. to suggest to Davis that the situation might be resolved in national convention. Morris Fishbein writes in his history of the American Medical Association:¹²

"Dr. Davis replied to those who considered the project 'impracticable if not Utopian' because attempts to assemble a National Medical Convention had failed in 1835 (Georgia's) and 1839 (New York's first) that the objectives were so important that efforts should be continued even though there were a dozen failures."

The Southern Medical and Surgical Journal began publication again in 1845 under the editorship of Paul Fitzsimmons Eve, M.D. Paul Eve was no less an idealist and crusader than was Antony. Receiving his degree at the University of Pennsylvania, the young physician of 25 years of age, while studying under some of the greatest surgeons in Europe, was appalled by the Russian advance on Poland in 1831. With the help of Lafayette, he became an army surgeon in Warsaw and for his work received that nation's Golden Cross of Honor. Soon after, he returned to Augusta to become the first Professor of Surgery at the Medical College of Georgia. His surgical career covered 45 years. He has been credited by Meigs as the first American to remove a uterus in toto. He was a pioneer in modern triphining, lithotomy, and tracheotomy, and Graham notes that he was the first to use chloroform in the United States.¹³ In 1851 he became the 11th president of the American Medical Association. In 1859 his love of national independence prompted him to serve as surgeon in the Italian army in their struggle with

Austria. During the American Civil War he distinguished himself at Shiloh and was appointed Chief Surgeon in the Army of General Joseph E. Johnston.

P. F. Eve was a strong supporter of Nathan Davis and defended him on more than one occasion in the pages of his journal. Upon noting the call for assembling by New York to be held on the first Tuesday in May, 1846, and stating the intention of the Medical College of Georgia to support such a meeting, he notes with animosity toward his medical alma mater, Pennsylvania:¹⁴

". . . more than ten years ago, the Faculty of the Medical College of Georgia proposed a similar movement on the part of the Profession in our country, and the proposition was favorably received; but in compliment to the University of Pennsylvania, the oldest medical school in the United States, the time and place for holding the convention and the number of delegates to be appointed, were left to her suggestion, and her faculty *then*, as *now*, declined to have anything to do with a convention."

And from a report of the committee appointed at the annual meeting of the New York State Medical Society (The Davis Committee) is quoted the following:

". . . the medical schools of Philadelphia are the only ones from whom replies have not been received, that decline sending delegates and giving hearty support to the proposed measure."

The national Medical Conventions of 1846 and 1847 served as preliminary meetings for the first Annual Session of the American Medical Society held in Baltimore on May 2, 1848. In a note written before his leaving for this meeting with Joseph Allen Eve as representatives of the Medical College, Paul F. Eve writes with pathos:¹⁵

"We don't expect to get any credit for it, still the fact may be stated that the Medical College of Georgia was organized in 1832, upon a six-month course of lectures. For the five following sessions the lectures commencing in the middle of October each year, and terminated in the middle of April in the following."

He recounted the 1835 attempt once again and the University of Pennsylvania's disapproval:

"Now the University of Pennsylvania is *claiming priority** of movement, and calling upon the profession to sustain her in the effort to establish a six-months course . . ." He further maintained that if any other medical college can prove that they made an attempt prior to 1832 to lengthen their course and kept it so for as long as five consecutive years, ". . . The Medical College of Georgia will yield all her claims to priority of action on the subject."

*Italics are the author's.

The main events concerning the proposals under discussion were directly quoted from a report published in *The Western Journal of Medicine and Surgery*, 1848¹⁶ as a Medical Intelligence:

"We continue our account of what occurred at the late (1848) meeting of the American Medical Association. 'Prof. Paul F. Eve of Georgia on the first day of the meeting proposed that the profession in the various medical schools present, should meet that evening for the purpose of interchanging views respecting medical education in the United States'."

That evening the meeting was held and the 17 leading schools were officially represented:

"... a resolution (was) offered by Professor Eve to the effect that the lecture term of the medical schools ought to be extended to five months ... the vote was decidedly in favor of the resolution of Doctor Eve's, and when the question came before the Association two days after ... the results were the same'."

An announcement appeared in Eve's journal the very next month after the convention: "... We are gratified to say, that the next course of lectures in the Medical College of Georgia will continue five months. ..."

Joseph Allen Eve sounded the keynote of his school's crusading struggle 12 years before, September 1836, in his profoundly far-sighted article entitled, "Medical Education," which appeared in Antony's old series of *Southern Medical and Surgical Journal*.

"The present defectiveness of medical instruction in the United States is acknowledged and deplored by the most enlightened and distinguished physicians in our country. ... The spirit of the times calls aloud for reformation—the rapid march of intellect—the numerous important discoveries and improvements ... require it, and ere long the voice of more enlightened people will demand it ... Is not the wide spread of empiricism in our country indubitable proof of the degradation of the profession, and of the necessity for improvement? ... Can the profession of medicine ever assume or maintain the elevated position it ought to occupy, whilst the courses of collegiate instruction are so imperfect, and degrees conferred on such meagre attainments? ... too many students desire no more—aspire no higher than to obtain a degree in as short a time and with as little exertion as possible—content to practice the honourable and exalted profession of medicine as a mere trade. ..."

"... the extension of the term to six months, although a very great improve-

ment upon the shorter course, is still but an approximation to the proper duration; lectures ... ought to be continued through the whole year, with the exception of one or two months vacation; the course should comprise many more branches than are taught in the schools of our country; and at least four years' attendance should be required to render a candidate eligible to the Doctorate and certain requisitions should be adopted with respect to preparatory education ..."

"So desirous for reformation have the faculty of the Medical College of Georgia been, since the first establishment of this institution, that they suggested the idea of calling a convention of delegates from all the colleges of the Union ... (it) is the only feasible plan by which a general reformation can be effected ..."

One can now realize the emotions that he must have felt when, 21 years later, Paul Fitzsimmons Eve in his opening address as president of the American Medical Association said:

"... you present again the sublime spectacle of brethren from all sections of this widely extended Union, congregated to devise the best means to relieve suffering humanity, and may I add, we are here with,

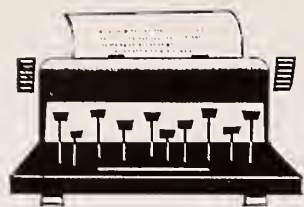
Our souls by love together knit,
Cemented, mixed in one;
One hope, one heart,
One mind, one voice."

Medical College of Georgia

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*Italics are the author's.



editorials

Is This Just Another Meeting?

THE FIRST ANNUAL CONFERENCE of County Society Presidents and Secretaries will be held Sunday, February 15, 1959 at 9:00 A.M. to 3:00 P.M. in Atlanta, sponsored by the Medical Association of Georgia.

Why should such a conference be held? What is the main purpose of the meeting? What is the meeting program? In short, how important is it for the newly elected 1959 officers of some 70 component societies to schedule a day in Atlanta—and what can be gained for the society represented at this meeting? These are the questions; here are the answers.

The purpose of the Conference is to improve county medical society operation and function. The leaders of each society will be given tangible recommendations on the basic structure of society organization; on county society management; on areas for society public service; on outstanding examples of society activity; and how MAG can aid its component societies.

To insure the practical “grass roots” approach of this “how to do it” meeting, the authorities and experts imparting this information have been chosen from the societies themselves. No lofty philosophies or didactic lectures will be given. Rather, the emphasis is on everyday procedures and how they are actually done best. The conference is tuned for a shirtsleeve workshop—to give society officers a basketfull of ideas to use during their term of office.

After a word of welcome from MAG President Lee Howard, Sr., the purpose of the meeting will be outlined in a keynote talk by T. A. Peterson of Georgia Medical Society. Rafe Banks, President of Hall County Medical Society, will lay out the five

“musts” which provide a firm foundation for building a good society. A panel of outstanding society members will then discuss County Society Management. Topics for the panel will be Parliamentary Procedure; Recording Minutes and Handling Society Business; Program Planning; and Society Community Responsibility and Jurisdiction. W. Bruce Schaefer of Stephens County will moderate this panel. The Eight Basic Areas For County Society Public Service will be discussed by J. Frank Walker of Fulton County with “take home” materials on this subject provided.

As a bonus feature, MAG will host a luncheon with a humorous chat by Mr. Leo Aikman of the *Atlanta Constitution*.

The Conference will reconvene with a presentation by Mr. Leo Brown, Director of the Communications Division of the American Medical Association. Mr. Brown will give illustrative examples of significant county society activity over the United States. Winding up the program will be a discussion of how the society can use the State Association to aid both the society as a group and its individual members. Thomas W. Goodwin of Richmond County will present this subject.

As there are 70 societies it is planned that each president and secretary attending will give an audience of some 140 society officers. It is the responsibility of the officers to their own society to attend this meeting. Invitations will be sent by MAG during the first week in January—and response is a “must.” Urge your officers to represent your county medical society. Mark the calendar for February 15—Atlanta, (scheduled just one day prior to the Atlanta Graduate Medical Assembly) and be there because this is not just another meeting; this is the meeting of the year for Society Officers.

The AMA and States Rights

A "STATES RIGHTS" trend was noted at the recent Interim Session of the American Medical Association in Minneapolis. Several times during discussions in the Reference Committees and in the House of Delegates, decisions on controversial matters were postponed with staff personnel instructed to survey the "constituent associations." A number of times, difficult matters were referred directly to the various state medical societies for action.

This is a welcome and healthy policy and is one which we have always tried to follow in Georgia. The policy of the MAG has always been to respect the wishes of the County Medical Society except in unusual circumstances. The County Medical Society is the first and final arbiter of medical problems in any particular area.

One of the most important matters referred to MAG and all physicians individually was the problem of health care of the aged. AMA House of Delegates recommended "that the AMA, the constituent and component medical societies, as well as physicians everywhere, expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources or low family income; that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and prepayment plans at a reduced premium rate."

Equally important was the House's action in re-

gard to the long-awaited report of the Commission on Medical Care Plans which was appointed at the 1954 Clinical Meeting in Miami. The House stated: "We respectfully suggest to the constituent associations reviewing the report in the interim, that their attitude regarding the report will be clarified if they arrive at some decisions in regard to the following points:

"1. *Free Choice of Physician*—Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?

"2. *Closed Panel Systems*—What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

"These suggestions acknowledge that the policy of the American Medical Association to encourage and support the highest quality of medical care for all patients remains unchanged. They question, however, whether attitudes toward the free choice of physician and the closed panel system may be undergoing evolutionary change."

As one can readily see, the emphasis on "States Rights" by the AMA puts quite a burden of responsibility on the individual medical societies. We must meet this challenge and respond with our opinions and actions. Only in this way can the AMA be guided by the thinking of *all* its members.

Blood Coagulation and Hemorrhagic Disorders

MUCH HAS BEEN ADDED to our knowledge of blood coagulation since Morawitz, in 1905, proposed the classical theory of the coagulation mechanism in which four factors were regarded as necessary, namely, thromboplastin, calcium, prothrombin, and fibrinogen. Today there are numerous researchers working only on this problem. In addition to many new factors and new theories, the terminology has become more confusing and there are many synonyms for the same factor or the same name for different factors. Also there are controversies as to classification and action of different factors and

arguments as to the significance of various techniques among the experts in this field.

Because of these problems many physicians have thrown up their hands and have brushed aside this subject as too confusing and too complex. In view of the importance of hemorrhagic disorders as regards their universality in practically every field and specialty in medicine, their frequent significance as to life and death of the patient, and their all too often unexpected emergency appearance, it behooves every physician to have some basic and practical knowledge of this subject. Who would have guessed a

few years back that one of the most recent and important advances in obstetrical knowledge and care has been the elucidation of hemorrhagic disturbances of pregnancy and the puerperium or that papers on coagulation problems would be common in surgical journals?

It now appears that there are three distinct phases in the clotting of blood, namely, the activation of thromboplastin, the formation of thrombin, and the production of fibrin. It is also felt that once coagulation begins it is an autocatalytic process, mediated through the first small amounts of thrombin formed, that progresses rapidly to completion. It must be remembered that there are physiologic inhibitor and anticoagulant mechanisms to prevent intravascular coagulation.¹

In any consideration of hemorrhagic disorders the problem of hemostasis must be viewed as a whole. The abnormalities of the coagulation mechanism are important, but we must not ignore other factors, namely, vascular (blood vessel), platelet factors (other than in coagulation), and the fibrinolytic mechanism. A single abnormality of one of the hemostatic mechanisms may not result in bleeding if all others are normal. As a corollary, severe spontaneous bleeding usually requires the involvement of more than one elementary hemostatic mechanism.

The approach, both diagnostic and therapeutic, to a patient with an actively present hemorrhagic disorder or the attempt to rule out a hemorrhagic disorder prior to contemplated surgery or other traumatic procedures should be based upon scientific rationale insofar as possible with our present state of knowledge. The old cliché, "a good history and physical examination are most important," still holds true in this group of disorders. In addition to the present history, the past history, family history, and drug history are invaluable. The types and location of the bleeding and other physical findings may be diagnostic (e.g. ecchymoses, petechiae, telangiectases, hematomas, hemarthroses, icterus, hepatomegaly, splenomegaly, adenopathy, arthropathy). The laboratory studies, however, cannot be neglected and are usually needed to confirm or make a definite diagnosis. With our increasing knowledge and increasing number of techniques in this field, many of the undiagnosed problems of the past are no longer mysteries today. Frequently, and probably true in most of our hospitals, there may not be available all of these procedures. There are, however, basic studies which are, or should be, available in every hospital laboratory to give us the diagnosis or lead us in the right direction. It is not only important to

know what tests are useful, but also to know that in certain situations some should not be done or should be postponed. For example, in a patient suspected to have hemophilia, a bleeding time may be dangerous because of continuous oozing from the puncture site. In an infant with this disease without a readily accessible peripheral vein (where adequate pressure can be maintained), a femoral vein or jugular vein puncture to get venous blood for diagnostic purposes may lead to rapid internal exsanguination. It is better to treat the patient as a hemophiliac and wait until he is older with an accessible extremity vein to confirm the diagnosis. Patients have actually required hospitalization as a result of a too avid attempt to obtain confirmatory diagnostic laboratory procedures.

At the same time, if no contraindication exists, one must realize that to adequately confirm or make a diagnosis of a hemorrhagic disorder or to demonstrate a coagulation or hemostatic defect, a battery of laboratory procedures must be done. This consists of a complete blood count with an examination of a peripheral smear to check the platelets (or platelet count), bleeding time, Lee-White coagulation time, one-stage (Quick) prothrombin time, prothrombin consumption time, clot retraction, and observation of the clot for fibrinolysis or dissolution. All of these tests should be correctly and adequately done by any good clinical laboratory. In addition, as part of the physical examination a tourniquet test should be performed.

Space does not permit going into the details of these laboratory studies and their significance as regards the different hemorrhagic disorders and their treatment. Suffice it to say that from the results of these procedures properly done, one can readily detect a coagulation disturbance, if present, and in what phase of coagulation the difficulty lies (thromboplastic, thrombin, or fibrin formation). Further studies may then be necessary to differentiate deficiencies of specific factors essential in each phase, but these basic screening procedures will point the way. They also will detect a vascular or fibrinolytic mechanism disturbance. Proper therapy depends upon the proper diagnosis. It should be pointed out that an increase in the quantity of factors concerned in coagulation does not accelerate coagulation if they are already present in optimal amounts (for example, giving vitamin K does not help if no vitamin K deficiency or prothrombin abnormality exists).

It is also important to realize that if one wishes to rule out a possible hemorrhagic disorder before contemplated surgery or other traumatic procedures, a routine bleeding and clotting time are inadequate. In addition, the coagulation time is frequently done

by the capillary tube method, and there is general agreement that this method is totally inaccurate. Diamond and Porter² studied and reported on this problem recently. They make a strong plea for the abandonment of routine presurgery tests of bleeding and clotting times on the basis of such inherent limitations as the occurrence of false-positive reactions and the fact that a normal result in no way assures a normal bleeding and clotting status in the patient. A carefully taken family history and past history and an adequate physical examination, as well as the examination of a peripheral blood smear, are suggested as being far more informative and effective screening procedures. If reliable laboratory studies are indicated, accurate platelet estimations

and the complete battery of coagulation studies must be done.

In conclusion, attention has been focused on the hemostatic mechanism in the study and treatment of hemorrhagic disorders. One must also remember the importance of hemostasis as regards thrombotic disorders and the promise for the more effective management in the future of these disturbances through anticoagulation and fibrinolytic agents.

Milton H. Freedman, M.D., F.A.C.P.

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DR. AUSTIN SMITH RESIGNS AS EDITOR

DR. AUSTIN SMITH has announced his resignation as editor of *The Journal of the American Medical Association*.

Dr. F. J. L. Blasingame, executive vice president of the American Medical Association, said that Dr. J. F. Hammond, associate editor of the *Journal*, will take over Dr. Smith's duties.

In a brief memorandum to the A.M.A. Board of Trustees, Dr. Smith asked that he be relieved of his editorial responsibilities December 15th, 1958.

Dr. Smith said that it is his conviction that after 18 years with the Association there is need for "new blood" in key administrative positions and although he has no immediate plans, he hopes to take a much needed vacation.

Dr. Smith has served as editor of the *Journal* since 1949. He succeeded Dr. Morris Fishbein. In addition to being editor of the *Journal*, he also has directed the editorial policies of the association's nine monthly specialty journals. *The A.M.A. Journal*, published weekly, exceeds 175,000 circulation.

Dr. Smith was born in Belleville, Ont., Canada. He received his M.D. degree from Queen's University Faculty of Medicine, Kingston, Ontario, Canada, in 1938 and in 1949 the postgraduate degree M.Sc. (Medicine) from Queen's University. He obtained his clinical training in Kingston and New York.

For two years he served as a member of the department of pharmacology, Queen's University,

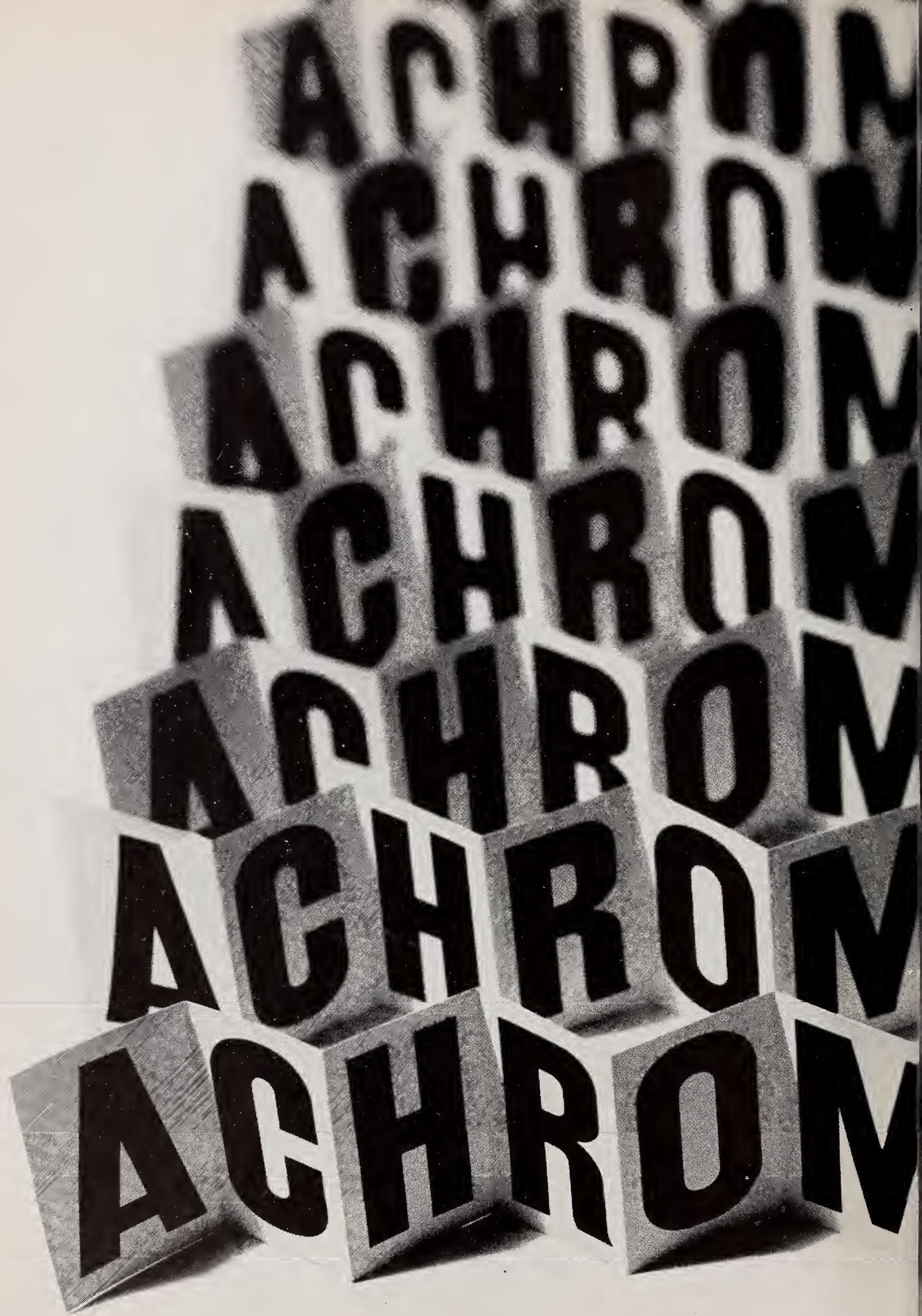
and later as a member of the staff of the University of Illinois College of Medicine, Chicago. For many years, he served as a professional lecturer at the University of Chicago, department of pharmacology.

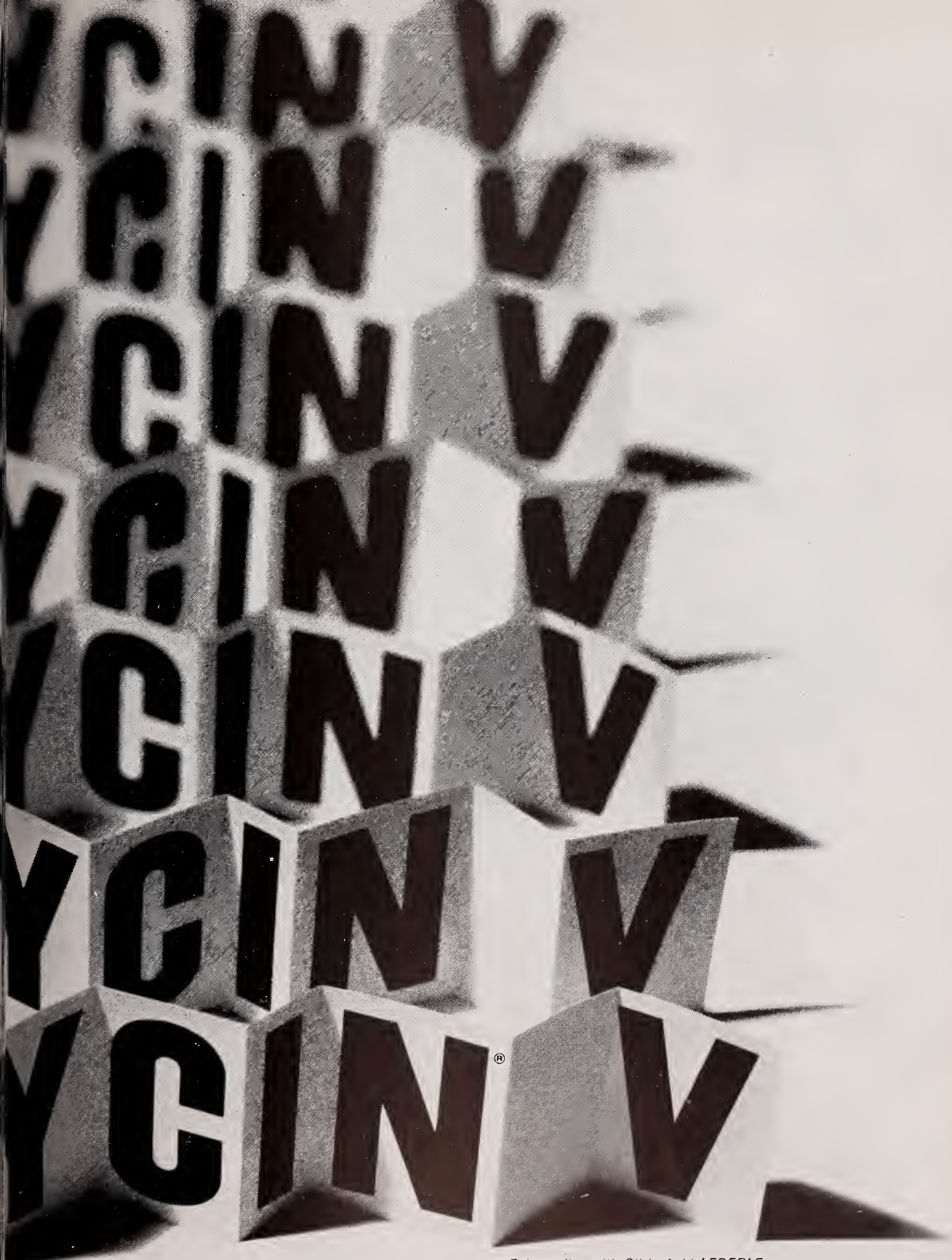
He joined the American Medical Association in February, 1940 as a medical consultant. In January 1942, he was made acting secretary of what is now known as the Council on Drugs, and in September of that year became secretary. In 1946, he also was named director of the Division of Therapy and Research.

On May 7, 1949, the *A.M.A. Journal* carried his name on the masthead for the first time as "assistant editor." He was appointed editor on December 1, 1949.

Dr. Smith has written scores of articles and books, both popular and scientific. He was distinctly honored in 1947 when he was elected to the Committee on Revision of the U. S. Pharmacopeia, which was adopted as standard in the Food and Drug Act of 1906. The book, containing a selected list of drugs, chemicals, and medical preparations, is revised every 10 years by a committee composed chiefly of physicians and pharmacists. He is also a member of the Division of Medical Sciences of the National Research Council.

"The American Medical Association accepts Dr. Smith's resignation with regret and is grateful to him for his many years of service," Dr. Blasingame said. "Every good wish is extended to him in the years ahead."





Tetracycline with Citric Acid **LEDERLE**

current clinical concepts

Demethylchlortetracycline

IN A NEVER ENDING search for new and more effective antibiotics the authors have found that this new tetracycline antibiotic produces much higher and better sustained levels of antibacterial activity in the serum than tetracycline after single or repeated doses. (Abstractor's Note: It is worthwhile to call to the attention of the readers of the *Journal* certain significant investigations by reliable investigators. Within a short period of time, no doubt, this new antibiotic, demethylchlortetracycline, will be marketed and because of its demonstrated superiority of activity the practitioner should be familiar with the results of objective research efforts). The therapeutic implications of the findings of these authors indicate that smaller and less frequent doses of this antibiotic preparation as compared with tetracycline may be required to produce the same systemic antibacterial effects.

Kunin, Calvin M. and Finland, Maxwell, A New Tetracycline Antibiotic That Yields Greater and More Sustained Antibacterial Activity, *The New England Journal of Medicine*, Vol. 259: 999, 1958.

Urinary Incontinence in Women

URINARY INCONTINENCE in women can be cured if at least one half the circumference of the vesical ring is freed and the tonic contraction of the normally retracted vesical sphincter can function.

Mulvany, John H., Vesicourethrolisis For Urinary Incontinence in Women, *S.G.&O.*, Vol. 107, No. 4 (October) 1958.

The Peripheral Venous Pump

PULMONARY EMBOLISM is now the commonest single cause of death following major surgical procedures. Venous stasis is the prime factor in venous thrombosis and subsequent pulmonary embolism. 73 per cent of thrombi begin in thigh or pelvic veins and 56 per cent of these subjects had associated pulmonary emboli. Irrespective of the site of the venous thrombosis, the venous pump in the calf muscles should be capable of increasing flow in the

calf, the thigh, and the pelvic veins and lessening the danger of thrombosis. . . . contraction of the calf will have a pumping action on the veins. When movement in leg muscles is reduced by putting the patient to bed, or even further reduced by an anesthetic and the post-operative period, stasis is inevitable and thrombosis may readily begin.

McLachlin, John; and McLachlin, Angus, *The Peripheral Venous Heart, Surgery*, 77: 568-575 (October) 1958.

Internal Diameter of Renal Artery

IT IS POSSIBLE to measure the internal diameter of the renal artery. A narrow renal artery is always indicative of reduced renal function, but an artery of normal caliber by aortography does not necessarily imply normal renal function. This is another in the series of recent papers in relation to studies seeking the etiology of hypertension.

Maluf, N. S. R., Internal Diameter of Renal Artery and Renal Function, *S.G.&O.*, Vol. 107, No. 4 (October) 1958.

Contralateral Inguinal Exploration

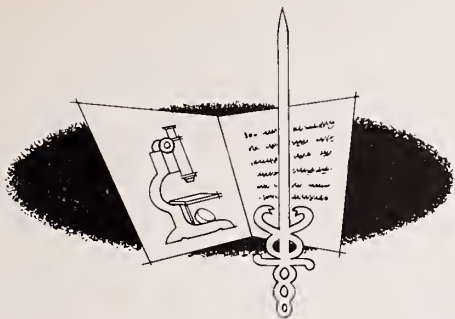
A RECOMMENDATION FOR exploring the opposite side will depend primarily upon the condition of the patient and experience of the surgeon. If the surgeon is skillful, mortality and morbidity should not be increased in properly selected infants and young children. However, contralateral inguinal exploration should not be done routinely.

Clausen, E. G.; Jake, R. J.; and Binkley, F. M., Contralateral Inguinal Exploration of Unilateral Hernia in Infants and Children, *Surgery*, 44: 735-770 (Oct.) 1958.

Direct-Vision Coronary Endarterectomy

FOR SOME TIME it has been known to the vascular surgeon that the most effective means of increasing myocardial blood flow would occur if the obstructing atheromatous plugs from the coronary arteries were removed. The authors have established that it is technically feasible to re-establish blood flow in previously obstructed major coronary arteries. They have subjected five patients with coronary atherosclerosis and typical symptoms of angina pectoris to direct-vision coronary endarterectomy. It was possible to remove all the occluding thickened intimal core from one or more of the coronary vessels and to re-establish blood flow through the vessels at the time of operation. With additional experience this technique of coronary endarterectomy may prove to be tremendous value in the surgical treatment of angina pectoris.

Longmire, William P., Jr.; Cannon, Jack A.; and Kattus, Albert A., Direct-Vision Coronary Endarterectomy for Angina Pectoris, *The New England Journal of Medicine*, Vol. 259: 993, 1958.



cancer page

PROFESSIONAL EDUCATION PROGRAM

THE PROFESSIONAL EDUCATION Committee of The Georgia Division, American Cancer Society, is striving for constant improvement of its program of information for the medical and dental professions, nurses, and laboratory personnel. We want to make it one of day-to-day usefulness in practice.

At the heart of the program is a series of symposia on tested techniques in the diagnosis and treatment of cancer. Two symposia have been conducted during the current fiscal year of the Georgia Division. The first one, in collaboration with the Medical College of Georgia, set a record attendance of 246 physicians and medical students. The second, at Hughes Spalding Pavilion of Grady Memorial Hospital in Atlanta, attracted more than half of the practicing Negro doctors in Georgia. Additional symposia are planned for Savannah, Valdosta, Americus, Augusta, and Gainesville. A program for pathologists and a cancer speaker for the dental profession's Thomas Hinman Mid-Winter Clinic in Atlanta will expand the series to a total of nine.

A new series offered this Fall is the use of a Physician Speaker's Bureau. Various M.D.-Members of the Board of Directors, Georgia Division, ACS, have agreed to present papers on cancer when the Committee receives requests from local Medical Societies. This service will be given on short notice, in case another planned program is disrupted, or when requests are submitted weeks in advance of the Society meeting. Of course, there will be NO expense to the Medical Society.

Another new program is the series of institutes on cancer and cancer nursing for students of practical nursing in the Vocational Education schools of the State. These courses also have attracted regis-

A. H. Letton, M.D., *Atlanta*

tered nurse students, public health and industrial nurses. The week-long course consists of lectures, demonstrations, films, literature, a field trip to observe research, and question-and-answer exchanges.

The Committee offers to medical societies, hospital staff meetings, and other assemblies attended by physicians a series of cancer kinescopes. These films were made during the live, closed-circuit television programs produced at various cancer treatment centers. The Fulton County Medical Society is currently presenting a kinescope at each monthly meeting. Other societies in Georgia have used these films and reported them helpful as an educational media.

The Committee mails to all physicians every two months the Society's medical publication, *CA—A Bulletin of Cancer Progress*. The current issue was augmented by a letter going to all Georgia Radiologists. The issue was devoted to cancer and radiation.

Another service by mail which has proven popular is a monthly postcard bearing a concise diagnosis and treatment message concerning various types of cancer. These are mailed to the dental profession whenever the card deals with cancer of the oral cavity. Such was the case with the latest one—on lip cancer.

Hundreds of physicians have taken advantage of the Committee's library of cancer literature. This stock includes pamphlets, booklets, and illustrations designed for the doctor himself, for his patients, for his nurse, and for his medical society.

Continued page 42

Approved by Professional Education Committee, Georgia Division, ACS.

Intensifying the Division's war on quackery, the Committee developed an exhibit which displays and demonstrates the actual gadgets and "medicines" seized from cancer quacks by federal agents. This exhibit has been seen by approximately 300,000 Georgians at 13 fairs, on seven television programs, at the Medical Association of Georgia convention,

at the "Conquest of Fear" in Rome last March, and at the nurse institutes.

The Committee hopes that members of the medical and dental profession, individually and collectively, nurses, and laboratory workers, will take advantage of this professional education program. A request stating your needs, mailed or telephoned to The Georgia Division, ACS, P. O. Box 1, 2025 Peachtree Road, N.E., Atlanta 9, Ga., will bring a prompt response.

1959 CALENDAR OF MEETINGS

State

- Feb. 15—Georgia Psychiatric Association, Atlanta.
- Feb. 16-18—Atlanta Graduate Medical Assembly, Atlanta.
- March 6-7—Georgia Society of Ophthalmology and Otolaryngology, Savannah.
- May 17-20—Medical Association of Georgia, Augusta.
- May 17—Georgia Pediatric Society, Augusta.
- May 17—Georgia Psychiatric Association, Augusta.
- May 17—Georgia OB-GYN Society, Augusta.
- May 17—Georgia Chapter, American College of Chest Physicians, Augusta.
- May 17—Georgia Radiological Society, Augusta.
- May 17—Georgia Diabetes Association, Augusta.
- Sept. 11-12—Georgia Heart Association, Atlanta.
- Sept. 18-19—Georgia Tuberculosis Association, Athens.
- Sept. 18-19—Georgia Trudeau Society, Athens.
- Sept. 20—Georgia Psychiatric Association.
- Sept. 24-26—Georgia Chapter, American College of Surgeons, Sea Island.

Regional

- Feb. 10-13—Mid South PG Medical Assembly, Memphis, Tenn.
- March 2-5—New Orleans Graduate Medical Assembly, New Orleans, La.
- March 9-12—Southeastern Surgical Congress, Miami Beach, Fla.
- Sept. 28-29—Tennessee Valley Medical Assembly, Chattanooga, Tenn.
- Nov. 14-17—Southern Medical Association, Atlanta.

National

- Jan. 21-23—American Diabetes Association, St. Louis, Mo.
- Feb. 2-4—American College of Surgeons (Sectional Meeting), Houston, Texas.
- Feb. 7-10—Annual Congress on Medical Education and Licensure, Chicago, Ill.
- March 5-7—14th National Congress on Rural Health, Wichita, Kansas.
- March 15-20—American College of Allergists, San Francisco, Calif.
- April 2-4—Association of American Physicians and Surgeons, Ft. Worth, Texas.
- April 6-9—American Academy of General Practice, San Francisco, Calif.
- April 13-15—American Academy of Pediatrics, San Francisco, Calif.
- April 19—American Society of Internal Medicine, Chicago, Ill.
- April 20-24—American College of Physicians, Chicago, Ill.
- May 25-29—American College of Cardiology, Philadelphia, Penn.
- June 3-7—American College of Chest Physicians, Atlantic City, N. J.
- June 8-12—American Medical Association, Atlantic City, N. J.
- Aug. 30—American Congress of Physical Medicine and Rehabilitation, Minneapolis, Minn.
- Sept. 27 - Oct. 2—American College of Surgeons, Atlantic City, N. J.
- Sept. 14-17—International College of Surgeons, Chicago, Ill.
- Oct. 3-8—American Academy of Pediatrics, Chicago, Ill.
- Oct. 23-25—American Heart Association, Philadelphia, Penn.



heart page

HYPOGLYCEMIA AND THE HEART

Jules Victor, Jr., M.D., *Savannah*

THE RELATIONSHIP OF HYPOGLYCEMIA and cardiac involvement in the past ten years has been extremely confusing. Hypoglycemia has been associated with the changes of the circulation such as increase or decrease in the heart rate, increase or decrease in the blood pressure, increase in venous pressure, increase in pulse pressure, the development of an abnormal heart murmur, and increase in heart size.

The explanation for these changes are not entirely clear. It was thought that the changes were probably due to loss of myocardial glycogen; however, it has been shown that the diabetic heart has a much greater than normal glycogen content in hyperglycemia and that with the administration of insulin the glycogen content falls only to normal. Even in the presence of very low blood sugars, insulin conserves the glycogen stored in the heart.

Recently, Hadsen and Hollender observed the effects of insulin-induced hypoglycemia in patients with angina pectoris. This group frequently developed alterations during the hypoglycemic state, which were not dissimilar to normal subjects. The electrocardiographic changes consisted of broadening, flattening, and inversions of T waves and disturbances in rhythm, such as premature beats, bigeminy, and ventricular tachycardia. The abnormalities were associated with decrease in the blood glucose and serum potassium. The changes in the T waves were not unlike that found in hypopotassemic state. They felt that in their group the absence of chest pain during the hypoglycemic state was further evidence that the electrocardiographic changes were not due to the coronary insufficiency

since they were totally unlike those observed during a documented attack of angina pectoris. Ganglionic blockade with hexamethonium failed to produce the electrocardiographic alteration. Episodes of disordered behavior, coma, or convulsions are frequently observed during the course of severe chronic congestive heart failure. When observed they may be considered as the process of anoxemia, cerebral disturbance, electrolyte imbalance, drug intoxication, directly related to the underlying cardiac pathology. It is important to remember that these occurrences may be the result of hypoglycemia and readily remediable by the administration of adequate glucose.

These episodes of hypoglycemia have been observed during the course of chronic long-standing congestive failure, due to a variety of causes such as rheumatic fever, syphilis, myxoma of the left ventricle, and coronary sclerosis.

The symptoms and signs of hypoglycemia are easily overlooked, such as sweating, palpitation, and convulsions. These may be produced by other conditions associated with advanced congestive heart failure. It is not surprising, therefore, that hypoglycemia has been frequently overlooked as cause of these manifestations and recognized ultimately by chance. Constant awareness that hypoglycemia may complicate the course of congestive heart failure will lead one to the diagnostic and perhaps life-saving measure of administering glucose.

It has been postulated that the hypoglycemia produced is hepatic in origin, secondary to long-

Continued page 44

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

standing passive congestion of the liver. Other possible causes have been ruled out by post-mortem and clinical observation. Other factors may play a role in the hepatic origin such as anoxemia, starvation, and shock secondary to circulatory collapse. It is believed that these are only contributory factors. A state of acute or chronic anoxemia is thought to produce hyperglycemia and not hypoglycemia.

Shock has never been noted to produce hypoglycemia.

In any event, the symptoms that have frequently been ascribed to being circulatory in origin may actually be due to hypoglycemia.

The symptoms of cardiac neurosis must be accepted as one feature of repeated hypoglycemic reaction. One should also strive to prevent hypoglycemic episodes, especially in the elderly diabetic patient with evidence of decreased cardiac reserve.

GOVERNMENT HEALTH INSURANCE LOSING FAVOR IN ENGLAND

CONTRARY TO EXPECTATIONS, voluntary health insurance in England has not been eliminated by the government health insurance program.

In fact, the people of Great Britain are now purchasing voluntary health insurance at an increasing rate.

An examination of the 10-year British program has led a New York researcher to conclude that a government approach to health insurance is neither necessary nor desirable.

This is reported by J. F. Follman, Jr., director, information and research, Health Insurance Association of America, in an article appearing in the (Nov. 22) *Journal of the American Medical Association*.

In his report, the author said, "it would seem a truism that voluntary health insurance protection in the United States today is on much firmer ground than was the case in Great Britain prior to the formation of NHS."

NHS is the National Health Service which went into effect in 1948. Before government intervention, voluntary programs limited their coverage to loss of income due to accidents or illness. Little coverage was written in the way of hospital or medical cost insurance.

The purpose of NHS was to provide comprehensive medical care and services to all the people with the costs to be borne by funds derived from taxation (payroll deductions and general tax funds). The author said these services included hospital care, medical care given by a physician, dental care, ophthalmic care, and drugs and appliances.

Certain forms of care, such as that in nursing or convalescent homes, are not provided under the NHS program and if private hospital accommodations are chosen, no benefits at all can be derived with regard to hospital care.

It was felt, however, that because of the vast

coverage offered by NHS, in time the voluntary programs would come to an end, the author said.

The converse now appears to be true, he pointed out.

In one program alone—British United Provident Association—there has been an increase from 34,000 contributors in 1949 to over 300,000 today. To this must be added the dependents of the contributors which would bring the total coverage to 600,000.

The principal coverage offered by this and similar plans is against the cost of maintenance in hospital private wards and nursing homes, cost of surgeons' fees, anesthetic services, consultants, specialists, home nursing care, therapy, and diagnostic services.

The benefits are directed at the costs of the more serious illness rather than at those of minor ailments, the author said.

He also cited four major reasons for the decline in interest in the government program and the sharp rise in contributions to the voluntary programs. These are:

(1) Continued increase of the cost of certain services provided under the government program. This is particularly true in the area of dental care, drugs, and optical appliances.

(2) Desire for private rooms which are not available under NHS.

(3) Limited number of government hospital beds. The author reports that at the end of 1956, it was estimated that 431,000 persons were on the NHS waiting list for hospital beds.

(4) Patients' lack of freedom of choice in the selection of surgeons, specialists, and consultants.

In conclusion, the author said, when one considers that health insurance in the United States is still growing rapidly, it would stand as a clear indication that a government approach on a broad population basis is neither necessary nor desirable.

1959

Annual Session

AUGUSTA • MAY 17-20, 1959 • BON AIR HOTEL

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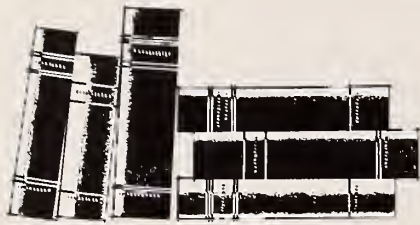
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(2) After the Bon Air Hotel is filled or as member's preference indicates, your reservation will be confirmed by other hotels or motels.



physician's bookshelf

BOOKS RECEIVED

- Sakel, Manfred, M.D., *EPILEPSY*, Philosophical Library, New York, N. Y., 1958, 204 pp., \$5.00.
- Mitchell, Roger S., B.A., M.D., F.A.C.P., and Bell, Carroll J., B.S., M.D., M.S., F.A.C.P., *MODERN CHEMOTHERAPY OF TUBERCULOSIS*, Medical Encyclopedia, Inc., New York, N.Y., 109 pp., \$4.00.
- Roberts, H. J., M.D., *DIFFICULT DIAGNOSIS*, W. B. Saunders Company, Philadelphia, Pa., 1958, 913 pp.
- Hirsh, Harold L., M.D., and Putnam, Lawrence E., M.D., *PENICILLIN*, Medical Encyclopedia, Inc., New York, N. Y., 148 pp., \$4.00.
- Carter, Richard, *THE DOCTOR BUSINESS*, Doubleday & Company, Inc., Garden City, N. Y., 283 pp., \$4.00.
- Weinstein, Louis, Ph.D., M.D., and Ehrenkranz, N. Joel, M.D., *STREPTOMYCIN AND DIHYDROSTREPTOMYCIN*, Medical Encyclopedia, Inc., New York, N. Y., 116 pp., \$4.00.
- Stearn, Lyon P., Ph.D., F.A.P.H.A., F.A.A.S., *THE BIRTH OF NORMAL BABIES*, Twayne Publishers, Inc., New York, N. Y. (December) 1958, 194 pp., \$3.95.
- Segaloff, Albert, M.D. (editor), *BREAST CANCER—The Second Biennial Louisiana Cancer Conference*, The C. V. Mosby Company, St. Louis (October) 1958, 257 pp., \$5.00.
- Woodward, Theodore E., M.D., and Wisseman, Charles L., Jr., M.D., *CHLOROMYCETIN*, Medical Encyclopedia, Inc., New York, N. Y., 159 pp., \$4.00.
- Marti-Ibanez, Flei, M.D., *MEN, MOLDS, AND HISTORY*, M.D. Publications, Inc., New York, N. Y. (December) 1958, 114 pp., \$3.00.

REVIEWS

Markell, Edward J., M.D., and Voge, Marietta, Ph.D., *DIAGNOSTIC MEDICAL PARASITOLOGY*, W. B. Saunders Company, Philadelphia, 1958, 276 pp., \$7.00.

A LABORATORY PARASITOLOGIST and two field epidemiologists who examined this book were very favorably impressed. On said in summary, "The information, while limited, is up-to-date," and "A complex subject has successfully been condensed into a simple readable form for those who do not have time to consult more definitive texts."

The chapter "Pseudoparasites and Pitfalls" emphasizes the very real need for physicians and others who do not routinely do microscopic parasitology to realize how shockingly easy it is to confuse a blood platelet with a malaria parasite or yeasts and polymorphonuclear leucocytes with intestinal protozoa. Similarly, a columnar or squamous epithelial cell in a stool can trouble experienced workers.

The authors have made liberal and successful use of microphotographs in the section on helminths but the section on protozoa depends more than seems necessary on theoretical line drawings. The chapter on "Arthro-

pods and Human Disease" is somewhat superficial and might well be expanded or omitted, whereas the consolidated discussion of all tissue parasites is a valuable aid.

The book is dedicated to the "late Professor Harold Kirby," a graduate of Emory in the Rhodes-Baker days. Dr. Kirby taught at California after receiving his doctorate there.

T. F. Sellers, Sr., M.D.

Cleave, T. L., M.R.C.P., *FAT CONSUMPTION AND CORONARY DISEASE: THE EVOLUTIONARY ANSWER TO THIS PROBLEM*, Philosophical Library, New York, N. Y., 40 pp., \$2.50.

THE AUTHOR of this booklet feels that man's problem with coronary artery disease is largely the result of "unnatural" foods, particularly fats.

A requirement for perfect adaption according to the Darwinian principle is that an animal develops a protective sense of taste that rejects any harmful food occurring in its environment. The author believes that man is so adapted, and given a free choice of natural foods would be guided by sense of taste to a safe and proper diet.

The author attempts to prove that fats encountered naturally, and chosen freely in amounts dictated by normal appetite, are safe. On the other hand, "unnatural" fats and other processed foods, forced in large amounts upon the victim by his wife and restaurateur, are the basis of coronary artery disease.

Obviously, the author has undertaken a tremendous task, and as one might expect, the conclusions seem hardly justified by the evidence presented. The booklet cannot be recommended as a clearly thought-out, well documented scientific study, but several chapters will be of interest to those with a philosophical turn of mind.

Grant Wilmer, M.D.

Noyes, Arthur P., M.D., and Kolb, Lawrence C., M.D., *MODERN CLINICAL PSYCHIATRY*, Fifth Edition, W. B. Saunders Company, Philadelphia, 1958, 694 pp., \$8.00.

ONCE AGAIN THE AUTHORS of this classic and comprehensive text and reference book have managed to improve upon previous editions by admirably including new therapies and ideas as well as new concepts and philosophies in the treatment and understanding of the psychiatric patient.

This volume is, as before, dynamically oriented and deals with the various mental disorders and their various therapies in a most complete and comprehensive way. The authors recognize the values of each of the separate limitations. The material on pharmacotherapy is current, detailed, and realistic as opposed to so much that is written today about drug therapy. This edition

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

also includes a chapter on psychiatry and the law which explains well the problems involved in hospitalizing the mentally ill, writs of habeas corpus, criminal responsibility, and competency.

Any criticism of this book or any work of this magnitude will seem petty. Since the authors have accomplished so much, it hardly seems appropriate to criticize them for a few omissions. However, one would like to see a somewhat greater space given to the personality disorders since more and more in psychiatry and in the general practice of medicine, one sees not the clear-cut neurotic symptomatology of old but a more perplexing and difficult to understand personality or characterological disorder which is leading to the interference in living which brings the patient to the physician's office, or which in turn may cause anxiety and one of the more clear-cut neurotic defenses against it. Unfortunately, the authors devote only three or four pages to the general subject of personality disorders, although they frequently refer throughout the book to the necessity of understanding the patient's pre-psychotic or pre-neurotic personality structure.

All in all this is an excellent work and would undoubtedly be a helpful adjunct to the library of any physician regardless of specialty due to its suggestions on management of such simple and frequently seen problems as hyperventilation syndromes, enuresis in children, the sedation of the elderly, etc. Its value to the student, resident, and psychiatrist is, of course, like its predecessors unquestioned.

Robert Van de Wetering

NEW AND NONOFFICIAL DRUGS, 1958, published under the supervision of the Council on Pharmacy, J. B. Lippincott Company, Philadelphia, 1958, 631 pp.

THIS PUBLICATION effectively bridges the gap between the text books of pharmacology and the Physicians Desk Reference. The practitioner is subjected to an avalanche of new therapeutic agents and an impartial description as found in N.N.D. is often helpful in his evaluation of them.

The book is well indexed for quick reference and the subject material is concise yet surprisingly comprehensive.

L. R. Scott, Jr., M.D.

Wolstenholme, G. E. W., and O'Connor, Cecilia M., (Editors for the Ciba Foundation), WATER AND ELECTROLYTE METABOLISM IN RELATION TO AGE AND SEX, Little Brown and Co., Boston, Mass., 1958, 327 pp., \$8.50.

THIS VOLUME represents the fourth colloquium in the Ciba Foundation's program for the encouragement of basic research relevant to the process of aging. Some eighteen papers, by many American and European authorities, are included.

The subjects presented encompass basic physiology, hormonal control of water and electrolytes, comparisons of water, electrolyte, and acid-base balance throughout the life span, and references to many of the disturbances seen in clinical practice. Particular emphasis is given to the effects of kidney senescence on electrolyte and water regulation but many of the papers included are of wider general interest.

At the end of each formal paper there is an informal discussion by colloquium members of the subject presented. These discussions are extremely stimulating and add interest and value to the presentations.

Some fundamental knowledge of the field would seem

to be advisable before reading this book as no didactic quarter is given the uninitiated.

Richard H. Johnson, M.D.

Flint, Thomas, Jr., M.D., EMERGENCY TREATMENT AND MANAGEMENT, W. B. Saunders Company, Philadelphia, 1958, 539 pp.

THIS TREATISE is a comprehensive, reference manual designed primarily for use in the emergency room or private office for the treatment and management of the patient from first examination until disposition for definite treatment can be made.

The book is divided into three sections. The first deals with general medical principles and procedures including miscellaneous topics from addiction to X-rays. The second section comprises the bulk of the book and covers emergency treatment of specific conditions. The 98 topics include about all of the common medical, surgical, obstetrical, gynecological, orthopedic, urological, and ophthalmological emergencies. The last section is of interest since it deals with administrative, clerical, and medicolegal principles and procedures.

Additions to this edition of timely interest are new or modified methods of treatment of barbiturate intoxication, cardiac arrest, cold injuries, diving injuries, vasopressor resistant shock, arterial damage and in the third section, the subjects, "Abandonment," "Court Testimony," and "Malpractice."

Litell S. Baird, M.D.

Lamb, Lawrence E., M.D., FUNDAMENTALS OF ELECTROCARDIOGRAPHY AND VECTORCARDIOGRAPHY, Charles C. Thomas, Springfield, Illinois (November) 1957, 138 pp., \$9.50.

THE AUTHOR THOROUGHLY develops the spatial vector approach to interpretation of electrocardiograms in the first portion of this book. After several chapters these principles are applied to the interpretation of the normal electrocardiogram. There then follows a section on the fundamentals of the vectorcardiogram with subsequent application to pathologic states. In the concluding section of the book the author presents a sketchy section on arrhythmias and gives some general comments on electrocardiographic interpretation. Despite the author's obviously sincere efforts to simplify the first portion of this book the reviewer feels that the average physician will have difficulty adequately following the text and will do better with other textbooks on the subject which contain this information in a more simplified form. The section on vectorcardiography is outstanding and amply illustrated. This section is highly recommended to those who have a good basic knowledge of the vector approach and wish to make the more advanced step into vectorcardiography.

Louis K. Levy, M.D.

Anson, Barry J., Ph.D., and Maddock, Walter G., M.D., CALLANDER'S SURGICAL ANATOMY, W. B. Saunders Company, Philadelphia, 1958, 1157 pp.

CALLANDER'S SURGICAL ANATOMY has become a classic over the years and the most recent edition, edited by Anson and Maddock, is an improvement over the previous editions. You will find much more clinical material in the new edition than has been apparent in the past, including many new drawings from the surgical anatomical articles of Dr. Anson. This book can be used with profit by medical students, residents, and surgeons alike.

Duncan Shepard, M.D.



the association

MEDICARE CONTRACT RENEGOTIATION

ON FEBRUARY 23, 1959, the Medical Association of Georgia will renegotiate the present Medicare Contract with the Department of the Army.

Prior to this renegotiation, the Medical Association of Georgia would like to point out some of the contractual terms which will be up for discussion and possible modification. These terms are those to which the Georgia physicians have raised objections.

Proposed Changes

The Contract now carries a provision that when the delivering physician renders normal hospital newborn care, he may charge only 50 per cent of the maximum fee allowed for such care when rendered by other than the delivering physician. It is felt by some that this is a discriminatory ruling which should be modified or eliminated in order to allow the maximum fee to any physician who normally so charges.

A second provision of the Contract is that a physician rendering obstetrical or post-operative injury care on an out-patient basis, may bill for necessary parenteral drugs. However, this billing is limited to the bare cost of the drug. No charge for administration, overhead, or breakage is allowable. Physicians contend that this provision is contrary to normal practice in Georgia; therefore, the Medical Association of Georgia will endeavor to have it changed.

Recommendations Requested

Recommendations or suggestions on the above points or other provisions of the contract which you, the physician, feel would better the Medicare Program would be deeply appreciated. Such recommendations should be directed to the Medicare Review Board, c/o The Medical Association of Georgia.

It is the general feeling of various government officials that the Medicare Program will be re-examined by Congress when it reconvenes with consideration being given at that time to increasing the Program to its former status. However, some areas of care previously offered will continue to be no longer available. But it should be noted that some type of care which previously was never offered under the Program will probably be offered if the Program is re-established on an increased basis.

Therefore, any recommendation as to care which the physician strongly feels should not have been eliminated under the October 1, 1958 cut back or as to any care which should be included in any reconsidered program will be greatly appreciated.

ANNOUNCEMENTS

Atlanta Graduate Medical Assembly, February 16-18, Convention Hall of the Atlanta Biltmore Hotel, Atlanta. An exceptionally comprehensive speaking faculty has been selected offering the widest variety of medical specialty topics ranging from allergy to nuclear medicine. Advanced registration fee is \$15.00. Checks addressed to the Atlanta Graduate Medical Assembly, 875 West Peachtree Street, N.E., Atlanta 9.

Sixth Annual Seminar on Cardiovascular Diseases, February 19-21, Prudential Auditorium, Jacksonville, Florida. Sponsored by the Northeast Florida Heart Association in cooperation with the Division of Postgraduate Education of the College of Medicine of the University of Florida. Course will include recent developments in the diagnosis and treatment of Cardiovascular Diseases. Formal lectures will be correlated with panel discussions and question periods in which the entire staff will participate. Accepted for credit by the AAGP. Write: Daniel R. Usdin, M.D., Cardiovascular Seminar, Northeast Florida Heart Association, 1623 San Marco Boulevard, Suite 7, Jacksonville 7, Florida.

12th Annual Postgraduate Course on Diseases of the Chest, March 30-April 3, Sheraton Hotel, Philadelphia. Presented by Council on Postgraduate Medical Education of the American College of Chest Physicians. The most recent advances in the diagnosis and treatment of heart and lung diseases, medical and surgical aspects. Tuition, \$100, including luncheon meetings. Write: Executive Director, American College of Chest Physicians, 112 East Chesnut Street, Chicago 11, Illinois.

Work shop on Foods and Nutrition, sponsored by the Foods and Nutrition Division of the University of Georgia, March 4-6, Center for Continuing Education, University of Georgia, Athens. Conference planned for persons engaged in Research, Extension, and Teaching of Foods and Nutrition.

SOCIETIES

The FULTON COUNTY MEDICAL SOCIETY has elected the following officers for the coming year. They are: J. D. Martin, president-elect; Lester Rumble, Jr., vice-president-elect; and Robert Carter Davis, senior member of the society's board of trustees. James H. Byram is the 1959 president of the society.

Simone Brocato was elected president-elect of the MUSCOGEE COUNTY MEDICAL SOCIETY at its annual meeting held in November. George Epps is the incoming president for 1959 succeeding Henry Boyter. A. C. Hobbs will serve as secretary-treasurer for the second year.

The Christmas meeting of the THOMAS-BROOKS MEDICAL SOCIETY was held December 4, 1958 at the Archbold Memorial Hospital in Thomasville. The scientific program included a paper presented by Benjamin R. Gendel of Emory University School of Medicine titled, "Hematologic Problems In Geriatric Practice," and the talk, "Aspiration Pneumonia—A Frequently Unrecognized Disease," presented by William W. Stead, University of Florida School of Medicine. Following the scientific program, a social hour, dinner, and dance was held at the Elks Club.

Officers of the SOUTHWEST GEORGIA MEDICAL SOCIETY were chosen at a dinner meeting held in Edison at the American Legion Clubhouse with Dr. and Mrs. J. B. Martin as hosts. Elected to serve during 1959 were: Homer P. Woods, Ft. Gaines, president; Turner Rentz, Colquitt, vice-president; and James B. Martin, Edison, secretary-treasurer.

DEATHS

WILLIAM CLARKE BLANDFORD, SR., Atlanta, died December 1 at the age of 71.

Dr. Blandford received his medical degree from Emory University after being graduated from the University of Maryland as a pharmacist. He worked as a pharmacist in Baltimore for several years before entering Emory. Dr. Blandford maintained offices in Atlanta and was semi-retired at the time of his death.

He was a member of the Phi Rho Sigma medical fraternity, the American Medical Association, the Medical Association of Georgia, and had recently been made a life member of the Fulton County Medical Society.

Surviving are his wife, the former Ethel Galloway; a son, William Clarke Blandford, Jr.; and nieces, Mrs. Glenn Blackston of Atlanta and Mrs. Murray Weems, Birmingham, Alabama.

H. A. BARRON, Thomaston, died November 16 at the age of 69.

Dr. Barron was born and received his early education in Thomaston and, briefly, was a rural mail carrier before entering medical school at Emory University. He returned to Thomaston in 1913 to begin a 20-year successful medical practice but, because of poor health, retired as a physician in the early twenties.

After his retirement from the practice of medicine he turned to politics for activity and served as city councilman, chairman of the Upson Board of Commissioners and, at the time of his death, was serving his third term as mayor of Thomaston.

Dr. Barron is survived by his wife, Mrs. Florrie Moore Barron of Thomaston; two daughters, Mrs. Sidney Nicholson of Thomaston and Mrs. Robert Jackson, Dalton; one brother, Brooks Barron, Jr. of Thomaston; three sisters, Mrs. Claude Morris, Pal-

metta, Mrs. Frank Andrews, Sr. and Mrs. Emmett Trice, both of Thomaston; and five grandchildren.

JESSE M. McELVEEN, 81, of Brooklet, died November 23 after a short illness.

A native of Bulloch County, Dr. McElveen graduated from the University at Augusta in 1902 and began his practice in Denmark, Georgia. Three years later he moved his office to Brooklet and practiced there until his health forced him to retire in the spring of 1955.

He was a Mason, a Shriner, a member of the Brooklet Kiwanis Club, and an active member of the First Baptist Church of Brooklet.

He is survived by his wife, Mrs. Sara Elizabeth Cone McElveen of Brooklet; three daughters, Mrs. Foy Wil-son of Statesboro, Mrs. Lanier Hardman of Covington, and Miss Louise McElveen of Brooklet; two sons, W. E. McElveen of Statesboro and J. M. McElveen, Jr. of Savannah; one sister, Mrs. Georgia Bunce of Statesboro; seven grandchildren; and several nieces and nephews.

JAMES BASCOM DILLARD, Davisboro, died November 18 at the age of 86.

A native of Newton County, Dr. Dillard had lived and practiced medicine in Davisboro for 59 years.

Survivors include his wife, Mrs. Maude Carroll Dillard of Davisboro; two sons, George B. Dillard of Davisboro and Dr. Steve D. Dillard of Milledgeville; one daughter, Mrs. M. C. Lewis of Davisboro; one sister, Mrs. Walter Dunlap of Pine Mountain; and six grandchildren.

JOSEPH E. JOHNSON, JR. of Elberton died October 30 after an extended illness at the age of 53.

A native of Elberton, he was a member of the First Methodist Church of that city.

Dr. Johnson was a graduate of the University of Georgia and the Emory School of Medicine in Atlanta. He had practiced medicine in Elberton since 1936.

In addition to his mother, Mrs. Georgia Heard Johnson of Elberton, he is survived by his widow, Mrs. Nell Steed Johnson; one daughter, Miss Roberta Ann Johnson of Elberton; two sons, Dr. Joseph E. Johnson, III of Johns Hopkins Hospital, Baltimore, Md., and Parks Heard Johnson of Elberton; one grandson, Joseph E. Johnson, IV, and one granddaughter, Judith Ann Johnson of Baltimore, Md.

BENJAMIN F. RILEY, JR. of Thomson, 79, died November 11.

A native of Alabama, Dr. Riley was graduated from the University of Georgia in 1898 and Johns Hopkins University in 1902. He went to Thomson in 1905 where he practiced for some 16 years. He then moved to Florence, Alabama, where he practiced for 10 years, returning to Thomson in 1932.

Survivors include four daughters, Mrs. D. P. Dixon, Miss Marilouise Riley, and Mrs. Lawrence Wylie, all of Thomson, and Mrs. Charles Chandler of Charleston, S. C.; two sons, Ben Frank Riley, III of Florence, Alabama and William M. Riley of Florence, S. C.; four sisters, Miss Lois Riley of Birmingham, Alabama, Mrs.

the association CONTINUED

Wallace Kilbourne of Muskogee, Oklahoma, Mrs. Percy Guice of St. Petersburg, Florida, and Mrs. N. C. Hoyt of Houston, Texas; two brothers, John Riley of Birmingham and Ashby Riley of Houston.

VIRGIL C. COOKE, formerly of Atlanta, died November 10 at his home in Tampa, Florida at the age of 81.

Dr. Cooke attended the Atlanta School of Physicians and Surgeons, now a part of Emory University, and was formerly on the staff of Crawford Long Memorial Hospital.

He was a member of the Fulton County Medical Society, Medical Association of Georgia, and the American Medical Association. He was a Mason and a member of the Yaarab Temple of the Shrine.

Survivors are his wife; two daughters, Mrs. H. B. Miles, Tampa, and Mrs. W. S. Turner, Savannah; a son, Virgil C. Cooke, Jr., Columbus; and a sister, Mrs. Clarence Willis, Sr., Barnesville.

PERSONALS

First District

CHARLES E. SAX of Savannah is the new president-elect of the Savannah Society of Obstetricians and Pediatricians. He succeeds EMERSON HAM as president-elect, and Dr. Ham has taken over as president.

Guest speaker at a recent meeting of the Millen Elementary School P.T.A. was JOHN ROBERT HARRISON who spoke on "The Child's Health Makes Better Homes and Better Schools."

Second District

No news submitted.

Third District

"The Doctor and the Nurse Work Together" was the title of the speech given by IVAN ELDER, Columbus, as the opening address of the Georgia State Nurses Association convention held in Columbus.

JACK McGEE and A. C. HOBBS were elected as Fellows to the American College of Surgeons at its annual meeting held in Chicago.

S. A. RODDENBERRY, Columbus, attended the Southern Surgical Conference recently held at Boca Raton, Florida.

Fourth District

The American Academy of Pediatrics has announced the election of A. STUART FITZHUGH of Griffin to Academy fellowship.

DESCOMBE WELLS, LaGrange, spoke to the Rose-

mont Elementary School P.T.A. at a recent meeting on the symptoms and dangers of tuberculosis.

GOODWIN G. TUCK, Covington, was the main speaker at a Kiwanis Club luncheon held in Covington. He discussed future plans of the Newton County Health Department.

Fifth District

Chief surgeon of the Scottish Rite Hospital in Decatur J. H. KITE, Atlanta, spoke to the Griffin Shrine Club at a recent dinner meeting on the activities and functions of the Shrine Hospital.

J. D. MARTIN, Atlanta, is the new president-elect of the Fulton County Medical Society.

Sixth District

EDWIN ALLEN of Milledgeville, who has been associated in the operation of Allen's Invalid Home at Milledgeville which was recently sold, has joined the staff of the Milledgeville State Hospital as a staff psychiatrist.

Seventh District

At the ninth annual election of medical department heads of Tanner Memorial Hospital, FRANCIS M. PARKS, Carrollton, was named chief of staff. He succeeds THOMAS E. REEVE, JR., who was named chief of surgery in the same election.

HOWARD C. DERRICK was elected mayor of Lafayette in the December annual election.

Eighth District

Dr. and Mrs. CARTER MEADOWS of Jesup recently returned from Chicago, Illinois, where Dr. Meadows became a Fellow of the American College of Surgeons at the annual Clinical Congress of the ACS.

ROY L. JOHNSON, Douglas, has been elected president of the Coffee County Chamber of Commerce for the coming year.

EUGENE C. KANE of St. Simons Island attended the annual meeting of the American College of Cardiology at New Orleans.

Ninth District

At a regular meeting of the R. M. Moore School P.T.A. in Canton, ROBERT JONES was guest speaker. He discussed common diseases and the care of children to prevent diseases.

Tenth District

Dr. and Mrs. RICHARD TORPIN of Augusta have left for Shiraz, Iran, where Dr. Torpin will serve for two years as head of the Gynecology and Obstetrics Department of the Medical Center of Iran.

Doctors from Atlanta who will appear on the program of the sectional meeting of the American College of Surgeons at Charleston, S. C., January 18-21 are: ROBERT L. BROWN, who will speak on "Tumors of the Neck"; TED F. LEIGH who will present the paper "Radiation Hazards in Diagnostic Roentgenology"; EDGAR F. FINCHER who will talk on "Neurosurgery of the Cerebral Vascular Lesions"; JOHN D. MARTIN, JR. who will be a member of the panel on "Abdominal Emergencies"; and MURDOCK S. EQUEN who will present the paper "Esophageal Obstruction."

THE MONTH IN WASHINGTON

IT IS NOW WELL-RECOGNIZED that the new 86th Congress, heavily spiced with newly-elected Democratic liberals, will set out to make an impressive record for itself. Health legislation will not be neglected.

On the basis of developments last session, and the known interests of many of the new members of Senate and House, here are the health areas where intensive activity is assured, with prospects for enactment of a number of bills either this year or next year, the final session of the 86th and also a presidential election year.

Social Security

Labor has announced that it will work this year for substantial changes in social security, the most important being a program for hospital-nursing home care for the aged and other beneficiaries. On this the unions are supported by the Democratic Advisory Council, which reflects the views of the Truman-Stevenson-Butler element of the party but generally finds itself to the left of Senate Leader Johnson, House Speaker Rayburn, and some other Congressional leaders.

Under social security, the AFL-CIO and the Democratic Council also would lower or drop the age 50 requirement for disability payments, increase the OASI taxes, bring more income under the taxes, and raise benefits all up and down the line.

American Medical Association, joined by scores of other associations and individuals in health and other activities, successfully opposed the social security hospitalization plan last session. They are prepared to wage just as determined a fight this year.

Aid to Medical Schools

An effort was made in Congress last session to provide grants to medical schools for building and equipping teaching facilities, to complement the research grants program already in effect. While the administration supported the attempt, it did not throw behind it all the energy it is expected to exert this year. Top officials of the Department of Health, Education, and Welfare, from Secretary Flemming on down, have been talking up aid to medical schools all fall. When time comes to testify, they will be strengthened by the activities of a new committee appointed to look into the schools' problems, as well as by the Bayne-Jones report which calls for the immediate start on construction of between 14 and 20 medical schools.

American Medical Association supports construction and equipment grants for medical teaching facilities. Strongest opposition this year is likely to come from some influential members of Congress, who succeeded in bottling up the legislation last session.

The Keogh Bill

Last session this legislation to permit the self-

employed to pay taxes on money withdrawn from retirement funds passed the House but failed to get out of committee in the Senate. Its sponsors, including the AMA, are hopeful that the Senate objections can be removed this year.

Medicare

Congressmen already have received protests from back home about restrictions imposed on the civilian phase of Medicare, mostly the channeling of service families to military facilities. This issue is sure to come up when appropriations hearings start on the Defense Department's budget. It may come up sooner, if Medicare runs out of money and requires a deficiency appropriation.

The Doctor Draft

The special draft, which hasn't actually been used in two years, may be invoked by the Defense Department this spring, if there isn't a better response on the part of interns and residents to the appeals for volunteers. Should the law have to be used this year, the Defense Department will have a pretty convincing argument that it should be extended beyond its scheduled expiration date of next June 30.

Medical Research

While the Federal government currently is spending at a rate of more than \$324 million on medical research through the National Institutes of Health, a still higher record of appropriations is in prospect for next year. The Senate Appropriations Committee has announced that never again will the pace of research be slowed through lack of dollars. This is also the attitude of the AFL-CIO and the Democratic Advisory Council, among other groups. The pattern usually is for the House to increase moderately Budget Bureau figures for medical research, then for the Senate to vote large additional increases. The House then generally agrees to spend close to what the Senate wants.

Contributory Health Insurance for Federal Workers

A new effort to bring about a contributory health insurance program for civilian federal workers is expected, with federal employee unions leading the drive.

Other Prospects

A number of amendments will be proposed for the Hill-Burton act. Some effort will be made to strengthen the law under which labor-management health and welfare funds must keep records and file reports. Hospitals are looking forward to low-cost loans under a community facilities bill and nursing homes to mortgage guarantees. The feud over VA's closing of 5,000 beds likely will be renewed.

Executive Committee of Council, November 23, 1958

CHAIRMAN OF COUNCIL George Dillinger called the Executive Committee of Council meeting to order at 2 p.m., November 23, 1958 at the Academy of Medicine, Atlanta, Georgia.

Members of the Executive Committee present in addition to Chairman Dillinger were Lee Howard, Sr., Savannah, President; Luther Wolff, Columbus, President-Elect; W. Bruce Schaefer, Toccoa, Immediate Past President; Chris J. McLoughlin, Atlanta, Secretary-Treasurer; and J. G. McDaniel, Atlanta, Chairman of the Finance Committee. Also present were J. Frank Walker, Atlanta, Chairman of the Legislation Committee; Eustace A. Allen, Atlanta, Vice-Chairman of the Legislation Committee and AMA Delegate; and John P. Heard, Atlanta, Chairman of the Public Service Committee. Mr. Milton D. Krueger, Mr. John Kiser, and Mrs. Emily Grinalds of the Headquarters staff were also present.

Minutes

Mr. Krueger read the minutes of the September 14, 1958 Executive Committee of Council meeting, and the minutes of the Executive Committee of Council Phone-call conference meeting of October 30, 1958. On motion (McDaniel-McLoughlin) it was voted that the minutes be approved as read.

Paramedical Personnel Recruitment

Public Service Committee Chairman John P. Heard explained to the Executive Committee what the Paramedical Personnel Recruitment program is. He asked three things of the Executive Committee, namely: (1) that they endorse the program; (2) send the Woman's Auxiliary a vote of thanks; (3) appoint two doctors to serve on the Paramedical Personnel Recruitment Committee when it is formed. On motion (Schaefer-Howard) it was voted that the Executive Committee accepts the Paramedical Personnel Recruitment Program as good, and refer it to the MAG Advisory Committee to the Woman's Auxiliary for further action, and whatever help they may need from the Executive Committee of Council.

Society AMEF Contributions Report

Mrs. Grinalds reported that eight County Societies have sent in 100 per cent contributions to the AMEF, and one other Society has made a partial contribution. The total amount received to date was reported at \$820. On motion (McDaniel-Schaefer) it was voted to send this money to the AMEF, and that a letter of appreciation to the Societies whose contribution was 100 per cent be written and signed by the President, and this be given publicity in the *Journal of the Medical Association of Georgia*.

Medicare Report

Medicare Administrator Mr. John Arndt gave a report concerning the MAG Medicare Contract. On motion (Schaefer-McDaniel) it was voted to continue the Medicare Contract with the government. On motion (Schaefer-McDaniel) it was voted to send a blank manual to eight County Societies, and a letter to the other 62 Societies asking them to submit any information they might deem necessary to help clarify codes and procedures.

Mr. Arndt announced that the new Medicare Review Board Chairman is W. Vernon Skiles, Jr., Atlanta.

On motion (McDaniel-Schaefer) it was voted that Mr. Arndt consult with Col. Lowrey for clarification of certain Medicare procedures.

GAGP Medicare Resolution

Mr. Krueger read a resolution from the GAGP Board of Directors as follows:

"The GAGP Board of Directors feels that under the present Medicare full-service contract the differentiation between the general practitioner and pediatrician in the care of the newborn is discriminatory against the general practitioner and further requests the Medical Association of Georgia Executive Committee of Council to renegotiate the Medicare contract to correct this apparent discrimination."

On motion (McDaniel-Schaefer) it was voted to approve this

request, and attempt to negotiate a change at the time of contract negotiation.

Miami 1960 AMA Meeting Funds and Other AMA Business

AMA Delegate Eustace A. Allen reported that there has been a request made that the Medical Association of Georgia extend financial assistance to Florida at the Miami 1960 AMA meeting and banquet (along with other Southeastern States) for the AMA House of Delegates. On motion (Wolff-McDaniel) it was voted to approve this matter, and to cooperate with the other Southeastern States at the 1960 Miami meeting.

In reference to the *AMA NEWS*, on motion (Schaefer-McLoughlin) it was voted to commend the AMA for their publication, the *AMA NEWS*.

Eustace A. Allen also suggested that the Southeastern States be organized into a group, and this was received for information.

Committee and Other Appointments

By general agreement, and on motion duly made and seconded, it was voted that the following committee appointments and replacements be made:

- A. MATERNAL AND INFANT WELFARE—Eugene Griffin, Atlanta to replace C. M. Mulherin, and to act as Chairman of this Committee.
- B. SCHOOL CHILD HEALTH—Edwin Sheppard, Savannah, to replace Thomas McPherson, and to act as Chairman of this Committee, and Robert Neil Poole, Atlanta, to serve on this Committee.
- D. INTERPROFESSIONAL COUNCIL—John G. Wells, Newnan, to replace Maurice Arnold (Term expired).
- E. MEDICARE REVIEW BOARD CHAIRMAN—W. Vernon Skiles to replace Charles Jones as Chairman.
- F. PRACTICAL NURSE ADVISORY—Lloyd Wood, Dalton, and Charles R. Andrews, Jr., Canton.
- G. AMA NEWS CORRESPONDENT—John F. Kiser, Atlanta.

Professional Conduct Committee Report

Mr. Kiser gave a report of the Professional Conduct Committee. It was voted to defer action on this report until the December meeting of Council.

President and Secretary Conference

Secretary Chris J. McLoughlin reported a proposed County Society President and Secretary Conference February 15, 1959, and outlined the proposed agenda. On motion (Schaefer-Howard) it was voted to approve this meeting of the County Society President and Secretary Conference for February 15, 1959.

Building Committee

On motion (Wolff-Howard) it was voted to empower the Building Committee to take an option on suitable property, if they deem it advisable.

Budget Committee Report

Finance Chairman J. G. McDaniel presented a proposed Budget for 1959, which was approved by the Executive Committee, and referred to MAG Council for action at its December meeting.

Distinguished Service Award

Chairman Dillinger stated that the Distinguished Service Award Committee composed of David Henry Poer, Atlanta; C. F. Holton, Savannah; and Ralph H. Chaney, Atlanta, is still in existence in an advisory capacity. On motion (Schaefer-Howard) it was voted to approve the status of this committee.

Headquarters Office Report

Mr. Krueger gave a report on Headquarters office activities. On motion (Wolff-McDaniel) it was voted to accept this report.

New Business

it was voted to approve this meeting of the County Society of MAG Council be held immediately following adjournment of Council in Valdosta in December, if a meeting is deemed necessary.

There being no further business, on motion (McDaniel-Wolff) it was voted to adjourn the meeting at 4:15 p.m.

Minutes of Georgia Hospital-Medical Mediation Council

THE GEORGIA HOSPITAL-MEDICAL Mediation Council met December 7, 1958 at the Academy of Medicine Building in Atlanta. Official delegates present were: Milford Hatcher, Medical Asso-

ciation of Georgia; Mark Dougherty, Medical Association of Georgia; R. C. Williams, Georgia Department of Public Health; Mr. David Hamilton, Association of Hospital Governing Boards; Mr. Arthur W. Smith, Georgia Chapter, American College of Hospital Administrators; Mr. Millard L. Wear, Georgia Hospital Association; Mr. Frank Allcorn, Jr., Association of Hospital Governing Boards; Mr. Geln M. Hogan, Georgia Hospital Association; and Mr. Milton D. Krueger of the MAG Headquarters Office.

The meeting was called to order by Chairman Milford B. Hatcher at 2:30 P.M. The minutes of the September 7 meeting were adopted as read.

Examination of Dr. Mauldin's Report

Mr. Krueger read the report through page 10 and the delegates present adopted by paragraph, with suggested alterations to some of the sections. At 5:15 P.M. on motion (Wear-Dougherty) the Council decided to continue its discussion of the proposed standards at the next quarterly meeting, taking up on page 10 (Part II—Section B). Chairman Hatcher directed the Secretary to re-write and duplicate the report as amended thus far, and mail to the delegates prior to the next meeting.

Resolution of Interprofessional Council of Georgia

A resolution from a pharmacists' organization in the state was read by Mr. Krueger, calling on the Mediation Council to include in its recommended standards certain provisions pertaining

to the dispensing of drugs in hospitals and other matters. On motion (Wear-Smith) action was deferred on the request pending further study of the resolution. The Chairman directed the Secretary to prepare copies of the resolution and make them available to members prior to the next meeting, for their further discussion and action at that time.

Proposed Revisions to Georgia Insurance Laws

Mr. Hogan advised the delegates of the scheduled hearings on changes in Georgia insurance laws, week of December 8. He emphasized the hearing on Chapter 56-18 pertaining to Non-Profit Hospital Service and Medical Indemnity Insurers, scheduled for December 12, 9:30 A.M., Room 341, State Capitol. Proposed changes in the enabling law for Blue Cross and Blue Shield plans would include several non-physician groups in the state. The Secretary strongly recommended that the hospital and medical groups of the state prepare to fight the objectionable features of the proposed changes to Georgia law.

Next Meeting

The Chairman set the next meeting in accordance with the previously adopted schedule, to be held Sunday afternoon, March 1, 1959, 2:30 P.M. in the offices of the Medical Association of Georgia.

There being no further business the meeting was adjourned at 5:20 P.M.

REVISED CERTIFICATE OF LIVE BIRTH

EFFECTIVE JANUARY 1, 1959, a new Certificate of Live Birth came into use by the Vital Records Division, Georgia Department of Public Health, to record live births in the state. The revised certificate follows the format of the Standard Certificate of Birth which was approved by the Public Health Conference on Records and Statistics, an organization of state directors of vital statistics and statisticians.

Since 1945 the Georgia Vital Statistics Law has required that a Certificate of Live Birth and a Confidential Medical Report be filed for each live birth occurring in the state. This dual system resulted from a birth registration check made with the 1940 United States census to determine the per cent of registrations being made in relation to the number of births. Georgia's registration was only 81.3 per cent.

To improve this, the Georgia Vital Statistics Law was passed requiring a Certificate of Live Birth to be filed by the parents and a Confidential Medical Report to be filed by the physician or midwife attending the birth. A registration check made with the 1950 census showed that Georgia then was registering 94.6 per cent of all state births.

The new Certificate of live Birth replaces the one used since 1945, but the dual birth registration system is still in effect. Some information formerly

on the Confidential Medical Report is now on the Certificate of Live Birth, thus enabling abbreviation of the medical report to a small 3 x 5 size. This helps the physician or midwife complete their report in much less time before mailing it directly to the Georgia Department of Public Health. The attendant at the birth will now also sign the Certificate of Live Birth in addition to the mother or father.

The old form was used to record 1958 births; however, all 1959 births must be reported on the new form.

Printed on the back of the revised Certificate of Live Birth is helpful information for the person filling it out. It is necessary that all items called for on the form be properly completed at the time the certificate is filed to prevent any future difficulty from improper registration. Particular caution should be taken to double check the information on the form for accuracy before it is filed with the local registrar as a court order is necessary to make any changes once the certificate has been filed with the Georgia Department of Public Health.

The size of the new certificate is now the same as that used for recording marriages, divorces, deaths, and fetal deaths. Distribution of the new forms were made to all local registrars and hospitals before the first of the year.

RESOLUTION APPROVED TO PROMOTE MORE INSURANCE FOR AGED

A RESOLUTION SETTING FORTH principles designed to promote more rapid spread of hospital, medical, and surgical insurance among people aged 65 and over was approved by member companies of the Health Insurance Association of America at a special meeting in New York City on Monday, December 8.

This action was taken by presidents and other top executives of member companies of the Association convened in a special session called by HIAA President Travis T. Wallace, President of the Great American Reserve Insurance Company, Dallas, Texas. The Association's membership represents over 80 per cent of the health insurance in force throughout the country through insurance company policies.

Directing itself primarily to the health care needs of Americans of advancing years and the future aged, the resolution emphasizes the need for continued development of insurance programs offering more adequate health cost coverage for retired workers and persons with impaired health.

"The purpose of the Health Insurance Association of America," the resolution says, "is to promote the development of voluntary insurance providing sound protection against loss of income and the expenses of hospital and medical care. It recognizes the individual and social importance of even more rapid expansion of voluntary health insurance among the ever-growing segment of the population aged 65 or older, of increased availability of health insurance for persons in impaired health and others whom voluntary health insurance might serve more effectively in the future, and of improved permanence of health insurance coverage generally."

"We have called this special session of the Association membership," Mr. Wallace told the assembled insurance executives, "to consider adoption of principles which we believe to be vital to our future development. None of the principles is new; in fact, the number of insurance companies so operating has been increasing steadily in recent years, and on a voluntary basis.

"It is estimated that 40 per cent of Americans 65 years of age and over now carry some form of health insurance protection in insurance companies and other types of voluntary insurers," Mr. Wallace said.

"Today insurers in increasing numbers are issuing health insurance which is guaranteed renewable for life or which becomes paid up for life at age 65," the HIAA President continued. "Many insurers accept new applicants to age 75 or above. An insurance

plan designed only for persons over age 65 is currently being offered by one major insurance company without requiring the applicant to furnish evidence of his insurability and providing coverage of pre-existing conditions after the contract has been in force for six months or more."

Principal features of the resolution approved at the special meeting of the Association are: insurers offering individual and family coverage of the cost of health care under contracts renewable at the option of the insurer should continue and accelerate their progress in minimizing the refusal of renewal solely because of deterioration of health after issuance; insurers offering health care coverages should, among the types of insurance contracts they offer, promptly make available to insurable adults policies which are guaranteed renewable for life; insurers should encourage the sale of permanent health care insurance where the need for this type of coverage exists, and insurers offering individual and family hospital, surgical, and medical care coverages should promptly take steps if they are not presently doing so to offer insurance coverage to persons now over age 65.

Moreover, the resolution states, it is essential that adequate voluntary health insurance be available to broad classes of physically impaired people. Initial insurance underwriting standards essential to fulfilling the first two of the recommendations increase the need for insurance for the physically impaired, the resolution says. It is recommended that each company carefully consider how it can contribute to the achievement of this objective.

Insurers writing coverage on a group basis, the resolution continues, should develop and aggressively promote soundly financed coverages that will continue after retirement, and insurers offering coverage on a group basis should encourage the inclusion in group contracts of the right to convert to an individual contract on termination of employment.

Discussing the growth of voluntary health insurance, Mr. Wallace told the meeting:

"Since the introduction of health insurance, insurers have offered sound protection to the greatest number in the shortest possible time. This has remained our responsibility to the people we serve. Health insurance protection through insurance company programs alone has burgeoned from 3.5 million persons covered in 1940 to some 72 million in 1958—more than a 20-fold increase in 18 years.

"At the same time, however, we must meet continually the challenge of improving existing forms of

coverage, and developing newer insurance programs in order to keep pace with the modern techniques of medical care and to keep our benefits in line with today's costs. This, too, is our responsibility."

Mr. Wallace pointed to the resolution, which said: "Because the Board of Directors of the Health Insurance Association of America believes not only in the urgency but in the feasibility of these objectives, it has made certain recommendations to the Association's member companies. The recommendations are not abrupt departures from the present practices of the industry. Each of them calls attention to the successful efforts of some or many companies, and urges consideration of their adop-

tion on a broader scale. The Health Insurance Association of America appreciates thoroughly that difficulties and major problems will be presented by these recommendations in some instances. It recognizes that companies will find some of the recommendations more difficult to adopt than others. They are made in the sincere belief that through their wider application the public interest can best be served and the status of voluntary health insurance can be enhanced."

"It is with this in mind," the HIAA President concluded, "that I call upon those companies not now doing so, independently to consider implementing the recommendations of this Association."

NEW DOCTOR OF YEAR HITS CASH GREED

THE NATION'S NEW family doctor of the year wishes all physicians would practice medicine from the humane side, caring for any patient needing their services.

And that's the life story of Dr. Lonnie A. Coffin, a kindly-mannered 68 year-old one-time horse-and-buggy doctor from Farmington, Iowa.

He was named general practitioner of the year by the American Medical Association's policymaking body, the house of delegates.

"I'm worried that a small minority of doctors look at their practice from the commercial side," he told a news conference. "But it is a very small minority. The majority of doctors do a good job."

To Dr. Coffin a good job has meant working days and nights as needed, seven days a week during his 44-year medical career in the small community of Farmington.

When he started practice in the horse-and-buggy era he was one of five doctors serving the town. Now, with the automobile simplifying the transportation problem, he serves the area alone.

Since suffering a heart attack eight years ago, he has limited the number of night calls. But he still works on Sundays.

Dr. Coffin, who said he doubts if he will ever retire, recalled he has delivered 2,500 babies—2,000

of them in their own homes. And he has helped handle many kitchen table operations in the past years because Farmington never has had a hospital.

What's the difference between today's medical patients and those of nearly half a century ago?

More of today's patients, both rural and in the town, suffer from psychosomatic complaints.

"It's tension caused by fastclip living," he said.

And he thinks the family doctor is well equipped to handle complaints of this type. The patient is close to his family doctor and comes to him naturally for treatment, advice, and assurance, Dr. Coffin said.

Dr. Coffin, a widower, was flanked at the news conference by his two daughters, Mrs. Helen Hols and Mrs. Betty Miller of Farmington.

He reflected about his most outstanding case. His answer was something of a surprise. The case didn't involve difficult candlelight surgery or a skidding buggy trip over country roads. It was nothing more dramatic than the injecting of a hypodermic needle into a boy critically ill with tetanus infection. But while tetanus was an old story for him then, it was his first experience with antitoxin. The boy lived. All the others before him had died.

—*Atlanta Journal*

MEDICAL RESEARCH ADVISORY BOARD URGED

THE NATION'S DRUG manufacturers have urged the formation of a top-level advisory board to advise on government policies in medical research.

In a letter to nearly 4,000 leaders in medicine, government, science, education, and industry, the Board of Directors of the Pharmaceutical Manufacturers Association asserted that unless immediate attention is paid to long-range problems in medical research, the consequences to the health and welfare of the nation will be serious.

The Association's letter, signed by P.M.A. President George F. Smith, president of Johnson & Johnson, suggested that the advisory body should be called the "National Council for the Advancement of Medical Research and Education." The P.M.A. Board suggested that the advisory body undertake a broad, impartial study of the sources of support for medical research—government, private industry, voluntary health agencies, and universities and medical centers—to evaluate and define their respective roles in the field of medical research and education.

The Pharmaceutical Manufacturers Association said that the need for such an advisory body was pointed up by the recent consultants' report to the Department of Health, Education, and Welfare on future needs in research and medical education. This report, sometimes called the Bayne-Jones Report, sets up several principles which the P.M.A. said are vital to the conduct of medical research in the U.S.

The substance of the P.M.A. resolution is as follows:

"RESOLVED. That the Board of Directors of the Pharmaceutical Manufacturers Association, an association of manufac-

turers of ethical pharmaceutical products:

- "1. Commends the Department of Health, Education and Welfare for its foresight and wisdom in choosing outstanding consultants to report on the vital and complex questions involved in the future direction of medical research and education;
- "2. Commends the consultants for the objective and analytical character of their report of June 27, 1958 known generally as the Bayne-Jones Report;
- "3. Believes that this report should serve as a guide to the thinking of all those concerned with the part the Federal Government should play in the field of medical research and education, but that no one report, however able, can at once solve all the complex problems involved;
- "4. Believes that further study and appropriate implementation of this Report should be given by a continuing committee, which will serve as a permanent source of top level advice to the Government authorities involved, which tentatively might be named National Council for the Advancement of Medical Research and Education, and

"BE IT FURTHER RESOLVED: That this Board recommends to the President of the Association that he forthwith appoint a committee to consult with other groups and leaders including but not necessarily limited to the following fields: medical education and research, the medical profession, government research, and the pharmaceutical industry; with the purpose of implementing this resolution."

1959 Annual Session

Medical Association of Georgia

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1959

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Georgia

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*Early evaluation of these
deformities must be carried out
if an ideal result is to be obtained.*

MANAGEMENT OF CONGENITAL DEFORMITIES IN INFANCY

Frank H. Stelling, M.D., *Greenville, South Carolina*

THIS DISCUSSION is limited completely to the management of congenital deformities during the first year of life. Every congenital deformity will not be discussed, but the more common types will be covered. A few conditions will be discussed in more detail because of recent changes in therapy.

Metatarsus Adductus

Metatarsus Adductus is one of the more common congenital deformities seen in infancy. Parents are often misdirected by their physician to leave this alone and see if it corrects. There has been little tendency toward spontaneous correction of this condition. In very mild cases whereby the forefoot can be passively overcorrected, the mother may be taught to stretch the foot. The heel is held securely while the forefoot is pushed over into abduction and held approximately two counts and released. This procedure should be repeated 20 times, four times daily. During rest periods, a swung out shoe is used. If there is a concomitant internal tibial torsion, a bar between the shoes is attached with the foot rotated outwardly 25 to 30 degrees. In most instances the foot is tight, and the deformity is fixed. In such instances it is necessary to apply plaster. A little plaster shoe is applied and the forefoot corrected, taking care not to evert the heel. The heel is then slightly inverted and the leg part of the cast applied. Casts are changed at one or two week intervals. The average foot is corrected after three to five cast changes. When the plaster

is removed, the regime described above for stretching and shoeing is instituted. If there is no recurrence for three months following the removal of the cast, the child is treated normally and normal shoes are worn for weight bearing.

Clubfoot (Talipes Equinovarus)

It is important that clubfoot be recognized at birth and treatment instituted at an early age. No one can improve upon Dr. Kite's methods for the treatment of this condition. The foot should be passively corrected by weekly changes of long leg plaster casts. The elements of the clubfoot should be corrected individually and in sequence beginning with the correction of the forefoot adduction, then the heel varus, and finally the equinus. The cast must be well molded to the foot and emphasis placed upon correcting at the proper pressure points. As Dr. Kite has emphasized, the navicular can be felt, and the pressure should be properly applied here in a lateral direction with counter-pressure at the cuboid. These relationships should be fully corrected before dorsiflexing the foot or recurrence is inevitable. Following full correction of the foot, the parents are shown proper stretching exercises, and clubfoot shoes are used for weight bearing. These cases should be followed carefully for long periods because of the possibilities of recurrence. If the foot shows no tendency to recurrence, the length of time between visits can be increased, but it is our policy to follow these children over a period of many years, even to adult life in most instances. A clubfoot shoe will never correct a clubfoot.

DEFORMITIES / Stelling

Plantar Flexed Talus

Vertical talus of congenital origin is an infrequent cause of severe flatfoot. It is one of the causes of rigid flatfoot, usually of severe degree. This deformity may be confused with calcaneovalgus foot in infancy but, if suspected, is readily differentiated because of the tight heel cord and tightness of the foot in valgus and one's inability to get the forefoot into equinus. We feel that in order to attain the best results, correction should be started during infancy. The foot should be corrected as well as possible by the use of repeated cast changes similar to clubfoot correction but in reverse manner. The forefoot should be molded into equinus until the forefoot is lined up with the vertical position of the talus, then the calcaneus and forefoot are swung into varus, the calcaneus being shifted under the talus. Once the foot is corrected, we have performed a Grice bone block procedure, and the medial capsule of the talonavicular joint is opened and imbricated and this joint then transfixed with a Kirschner wire. Once bony incorporation of the bone block is evident, the foot is brought up. It may be found that the heel cord is very tight, and in these instances heel cord lengthening may be necessary. Once the foot is fully corrected and the bone block is incorporated completely, normal shoes are worn.

Calcaneovalgus Foot

Calcaneovalgus foot is a deformity frequently found at birth. The heel is in eversion, the forefoot abducted, and the os calcis is in marked calcaneus position. Most of these deformities are mild and tend toward spontaneous correction; however, most of them do not correct completely. The milder cases can be treated by stretching. The mother stretches the foot 20 times, four times daily. The forefoot is pulled down while the heel is pushed upward and the forefoot inverted. Sometimes the soft tissue structures are very tight, and the stretch-

ing should be preceded by cast correction, changing the cast every week for about three to four cast changes followed by the exercises described above. When older, the child is fitted with a supination last shoe.

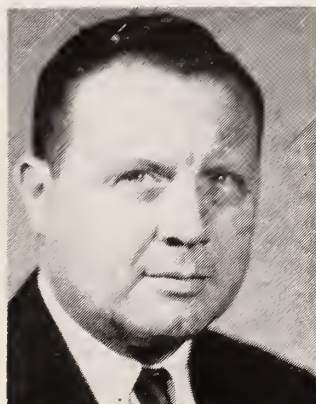
Congenital Torsion of the Tibia

This may be an internal torsion or an external torsion, but in our experience internal torsion is far more frequent. This condition is not a result of sleeping postures, but its tendency toward spontaneous recovery may be halted or delayed by sleeping postures. The child sleeps in the knee-chest position with the feet turned under in inversion resulting in increased internal torsion or with the feet in eversion resulting in external torsion. The child is fitted with shoes attached to a Denis-Browne bar with the feet in about 30 degrees of eversion on a long bar for internal torsion or in 30 degrees of inversion on a short bar for eversion. This is used for sleeping purposes. The rotational change will usually be corrected by the time of weight bearing. Walter Barnes has added a very nice refinement to the Denis-Browne bar for these conditions by bringing the bar up in an inverted V between the knees with a strap so that the rotational change is distributed to the leg and valgus or varus strain on the knees prevented.

Posterior Bowing of the Tibia

Posterior bowing of the tibia is an infrequent deformity seen at birth and is occasionally mistaken for a very severe calcaneus foot until the leg is really examined. It is then realized that the severe calcaneus is primarily due to a definite posterior bow in the tibia. Usually there is a coexisting calcaneus, to be sure. In some of these cases, there may be a little twisting tendency particularly toward external torsion of the distal part of the leg and foot. It is one's first impression that an osteotomy should probably be performed; however, it is rather dangerous to do osteotomies in the distal tibia because of the possibilities of interference with blood

ABOUT THE AUTHOR



FRANK H. STELLING, a graduate of the University of Georgia Medical School, did his residency in orthopedic surgery at the Gallinger Municipal Hospital, Washington, D. C.

Dr. Stelling is orthopedic surgeon for area two, South Carolina State Crippled Children's Division, orthopedic surgeon for Southern Railroad, and Medical Advisor to Liberty Mutual Insurance Company. He is also affiliated with several state hospitals. Dr. Stelling is a member of the Southeastern Surgical Congress, the World Medical Association, the American Academy of Orthopedic Surgeons, the South Carolina Orthopedic Association, the Association of Southern Railway Surgeons, the South Carolina Industrial Medical Association, the American Academy of Cerebral Palsy, and a Fellow of the American College of Surgeons.

supply and pseudoarthrosis. Experience has shown that if these are left alone or treated carefully by proper casting, shoeing, and observation, the majority of these deformities will tend toward correction. In those instances where there is a calcaneus foot, and this is true in almost 100 per cent of cases, we begin by using a short leg cast bringing the foot down and the heel up, changing the cast at intervals until the proper relationships between the foot and ankle itself have been attained. As the child develops, we use a little night splint along with stretching exercises similar to those used for true calcaneovalgus foot, until the time of weight bearing at which time usually a normal or supination last shoe is used. If one follows these children by X-ray, it is noted that the tibia tends to spontaneously correct from year to year until full development is attained. At times the tibia on this side does not grow quite as rapidly as on the other and, therefore, as the child grows, skeletal growth studies and bone age studies should be instituted.

Congenital Anterior Bowing of the Tibia

Congenital anterior bowing of the tibia is a little more frequent deformity than that of posterior bowing of the tibia, and these two conditions should in no way be confused as their prognosis is completely different and the treatment is no way similar. The anterior bowing of the tibia is practically always seen at the junction middle and distal third of the tibia. It is also practically always accompanied by either complete or partial absence of the fibula and most often by some partial absence of the lateral part of the foot, the most common being that of the lack of the lateral two rays and a tendency to valgus position of the foot. There is a little equinus element present in practically all of these cases with rather unusually tight gastroc soleus group of musculature. The congenital anterior bowing of the tibia is very resistant and rather than tending to spontaneously correct as the posterior bowing, it actually continues in the same proportion of angulation or in some instances tends to increase. The equinus of the foot is very hard to correct and usually if it has been corrected with cast methods, there is a strong tendency for recurrence. Until recent years, great difficulties were encountered in treating this condition and often we resorted to osteotomies, sometimes with disastrous results. It is now recognized that the absent or partially absent fibula is one of the elements that produces the bowing of the tibia and also accounts for the tendency to recurrence and the difficult situation of trying to correct these conditions. The remnant of fibula may be represented as a fibrous or cartilaginous band, and frequently it is attached to the os calcis itself along its superior and lateral border. Excision of

the fibular remnant is the best therapy for this condition during early infancy. Often the lower end is attached by cartilaginous element to the os calcis. After excising this fibrous or cartilaginous band, the foot can then be brought up to proper position and relationship in the ankle with frequent cast changes. The anterior bowing of the tibia tends to improve. This is best done during infancy as it prevents some of the more severe bowing that occurs during this period of life.

Acetabular Dysplasia and Congenital Dislocation of the Hip

Dr. Vernon Hart in his treatise on Dislocation of the Hip emphasized the fact that although children were born with a congenital subluxation or congenital dislocation of the hip, most congenital dislocations or so-called congenital dislocations actually were postnatal in development and occurred secondary to dysplasia of the acetabulum. The signs of acetabular dysplasia at birth and in early infancy are similar to the findings that one sees with a congenital subluxation or congenital dislocation, but the findings are much less noticeable and much less severe. If the acetabular dysplasia can be diagnosed early, many subluxations and dislocations, which are much more formidable as far as treatment and later developments are concerned, may be prevented. Once the clinical diagnosis of congenital dislocation or acetabular dysplasia is suspected, X-rays should be made, and usually the typical findings of such conditions are present; however, in the cases where there is definite clinical evidence of an acetabular dysplasia with tightness of the adductors, a tendency toward false shortening of the leg on the ipsilateral side and a little shift in the pelvis, these cases should be treated regardless of what may appear to be normal X-ray findings. In those cases of true dysplasia without the subluxation or dislocation, the method of choice is that of the use of a Frejka pillow. One of the many types of abduction splint can be used advantageously but, in our experience, the Frejka pillow is a little easier and attended in these instances by just as good results. The treatment should be carried out using the pillow or splint night and day at all times except for bath periods for at least a period of three months. If the tightness has disappeared and the X-ray shows normal relationships, then the splint can be used at naptimes and at night for another three months. At the end of that time, the relationships should be normal and, if so, all treatment can be discarded having the child come back for observation. If there is any evidence of development other than normal, the splint should be used until normal relationships are seen. Ponseti feels that if there is definite evidence of a prenatal dislocation,

some type of reduction is going to have to be performed and the hip cannot be reduced if completely out at birth. In our experience this has been true. The hip should be treated as to the length of time the hip has been dislocated and not according to the child's age. The hip may have been out longer in one child at birth than another child at one year of age who has suddenly developed a postnatal dislocation following a nontreated acetabular dysplasia. Treatment of the dislocated hip by closed or open reduction immediately brings up the problem of avascular necrosis of the head of the femur. Most of us know how to reduce a dislocated hip and hold the hip reduced in proper relationship to the acetabulum; however, in many instances whereby the hip must be manipulated under anesthesia and held in a solid plaster cast over many months, so-called epiphysitis or aseptic necrosis of the head of the femur will develop. Many years ago, Dr. Crego at the Shriners' Hospital in St. Louis realized this and since 1931 has not used this reduction of a dislocated hip in any age group without previous traction. We have come to feel that this is proper. In the small infant, we have admitted the child and used skeletal traction by the use of a Kirschner wire through the distal femur, and in order to enhance the efficiency of our traction, we have used a little spica cast applied to the normal leg in order that we increase the weight of the child; then the child is placed in Trendelenburg position and traction applied directly in line with the body. Usually soft tissues are relaxed in a period of two to six weeks. If the neck and head of the femur come into proper relationship by X-ray with the poorly developed acetabulum, then the leg is abducted and internally rotated, and quite often even without anesthesia, the head will slide right into the acetabulum. At that time, a spica cast can be applied with the hip reduced in external rotation and abduction. This is left on for a period of approximately two months. At that time, new X-rays are made and the cast is changed. If the acetabulum is developing well, the cast is cut down to a short leg cast on both sides and the child allowed to be a little more active. This helps tend to mold the acetabulum. After another two months this cast is removed, and if relationships are developing properly, the abductor splint is applied and used until normal relationships are seen by X-ray. In the children over one year of age, the treatment is definitely somewhat different. This treatment is that of the infant before the age of one year, and in no instance have we seen reason to perform any osteotomies in this young age group.

All of us realize the poor prognosis attending the treatment of spina bifida and myelomeningocele, and I am speaking of those with true myelomeningocele and paralytic involvement of both lower extremities, the usual loss of bladder and rectal sphincter control, and the deformities attended by the imbalance in musculature. We feel that these conditions pose a great challenge and in many instances with proper education, understanding, and help at home, much can be done for some of these children. As far as the medical therapy is concerned, it is a combined problem involving the orthopaedist, the neurosurgeon, the urologist, and the pediatrician. Those cases seen by us under the age of one year are advised to see a neurosurgeon, and it is our definite feeling that in those instances whereby there is no leakage of spinal fluid or no preeminent leakage, the sac itself be left alone and the child be allowed to develop as he will. In many instances, the child will die before the age of one year. If, however, the child seems to develop and it is evident that he will live, the sac possibly having been repaired or no need for repair has been seen, the clubfoot deformities or calcaneovalgus deformities (whichever exist) are corrected in the usual manner by cast treatment and held corrected by some form of brace. We have not attempted to reduce dislocated hips. These have been left alone. An effort has been made to try to stretch out tight structures about the hips, but we do not attempt to place the head of the femur in the acetabulum. If there are coexisting deformities of the knees, these are stretched out and splinted properly in neutral position.

In summary, we attempt to correct the deformities about the foot and knee to the point whereby the child can be managed in a paralytic brace. We know that the majority of these children who have rather severe paralysis will have to be braced indefinitely, and if we are able to correct some of the deformities during the early ages, it makes our problem later much easier as far as bracing is concerned. The only other thing that we advise during this period of infancy is to attempt to develop the shoulders and upper extremities to a maximum by exercises at home looking forward to use of crutches at a later date.

Congenital Torticollis (Muscular Torticollis)

Congenital torticollis, manifested by the tilting of the head toward one shoulder and rotation of the chin toward the opposite shoulder, is most frequently observed immediately after birth, often accompanied by a little mass or tumor in the sternocleidomastoid muscle of the side toward which the head is flexed. If this condition is seen in early infancy, in

the majority of instances the deformity can be completely corrected by gentle but positive stretching of the involved sternocleidomastoid muscle. The mother is advised to stretch the neck about four times daily, using gentle but firm stretching 20 times at each session. The head is held firmly between the hands, the chin rotated toward the opposite shoulder, and the neck flexed toward the opposite shoulder from its original position. If this is done gently over a period of several months, one finds the sternocleidomastoid muscle will stretch out and remain so. Along with the stretching, it is well to use other methods whereby the child will keep its head turned properly, such as positioning the crib so that the child will have to look to the opposite side for interesting activities. The child should be fed from the side opposite the tight sternocleidomastoid muscle. There is no need for excision of the mass or any surgical intervention during the period of infancy. In those instances that have not been corrected by the foregoing method of treatment, after a year the best method of approach is that of sectioning the tight sternocleidomastoid muscle.

Congenital Deformities of the Hand

It is our feeling that the usual congenital deformity of the hand including syndactylism, brachydactylia, clawhand, polydactylia, symphalangism, and congenital absence of certain musculature should all be left alone until the child is somewhat older. The exceptions to this are congenital clubhand, trigger thumb, or stenosing tendovaginitis of the thumb. In those cases of polydactylia whereby the appendage is poorly developed and attached only by a fine thread of skin, the appendage is usually tied off by the pediatrician at the time of birth. In the case of the trigger thumb or stenosing tendovaginitis of the thumb with flexion deformity of congenital origin, when the child has reached the age of approximately six months, a small transverse incision should be made at the proximal flexion crease of the thumb and the tendon sheath exposed and split. The thumb can be immobilized with a little Ace bandage for several days until the wound is healed, after which it will be found that the use of the thumb is perfectly normal. The only complicating factors that should be mentioned here are that one should be careful about protecting the neurovascular bundle and that the incision be transverse and never longitudinal which would produce flexion scarring.

Congenital Clubhand

Congenital clubhand is an infrequent congenital anomaly but a deformity which produces a rather poor cosmetic appearance and makes for a rather poor functioning upper extremity. Until recently, one usually elected to leave these alone and let the child

adapt to what function he could, or in later years a wrist fusion was performed for the purpose of getting the hand in as good position as possible but quite often with poor functional result. Riordan has recently advocated the method described by Starr in treating these conditions and has shown rather good results so far. In those cases that we have performed, the child has been anywhere from four to seven years of age. Riordan, however, feels that better results might be expected if we do this under the age of one year. The procedure is that of stretching the hand over the ulna, quite often by the use of plaster. This may be done without surgery possibly in the small infant before the soft tissue structures have become very tight. Once the wrist and hand have been mobilized over the distal ulna, the proximal end of one of the child's fibulae is dissected free extra-periosteally and grafted into the distal end of the ulna on its radial side into a small V-shaped notch and secured by threaded wires using the epiphysis of the upper fibula to act as an epiphysis for the distal radius. This epiphysis is approximated to the radial side of the carpus and then the wound is closed and plaster applied immobilizing the elbow at 90 degrees and the wrist in neutral position. This is left in place for approximately eight weeks until the bony union has become mature. Then the wrist and fingers are mobilized. The incision for this procedure should be along the radial side of the wrist, and it is best done and closed in a Z-shaped manner in order to prevent longitudinal scarring along the radial border of the hand and wrist. The other complicating factor of which one should be well aware is that the median nerve is quite superficial and along the radial side of the wrist just where our skin incision will be made. It is the most superficial structure and could easily be damaged in making the incision. At this time we have been quite happy with our results similar to the experience of Riordan, and we are looking forward to seeing what might be gained by performing these procedures during the stage of infancy before the age of one year.

Summary

Congenital deformities should be looked for and diagnosed early. Congenital deformities of extremities and spine should be seen early by the orthopaedist. Sometimes no treatment will be advocated until after the age of one year. In some instances, early surgical procedures are called for. In many instances serious complications may be prevented by early proper care of these deformities. Often the early therapy is simple, but late treatment of the same or complicated condition may be formidable or even impossible.

9-11 Medical Court

SLUDER'S HEADACHE AND ALLIED NEURALGIAS

Thirty years experience in the management of these conditions constitute the background for this report.

Wesley C. Thomas, M.D., *Brunswick*

IN 1908 GREENFIELD SLUDER¹ of St. Louis published his first paper on Sphenopalatine neuralgia, titled "The Role of the Sphenopalatine Ganglion in Nasal Headaches." This was followed in 1909 by "The Anatomical and Clinical Relations of the Sphenopalatine Ganglion to the Nose and Accessory Sinuses." He continued to furnish medical periodicals with papers—40 or more—on Nasal Ganglion Neurosis, and pertinent matter related thereto until 1925. In 1927 his book "Nasal Neurology, Headaches, and Eye Disorders" was published. All his writings show that he gave much thought to the study of the patients' complaints, physical findings, and especially to the minute anatomy of the nasal chambers, accessory sinuses, tongue, and pharynx. Relationship, anatomical and clinical, of nerve trunks in and adjacent to the nasal chambers and accessory sinuses seemed to be his special interest.

After spending nearly three years in New York hospitals in preparation for a career in pediatrics, I was called into the army in World War One. Two years in the military service brought me in contact with young men who suffered from what the military called "Cat Fever" with its accompanying headaches and sinus infections. This caused me to forget pediatrics. On my return to civilian life, I went to New York Eye and Ear Infirmary to continue the study of ear, nose, and throat conditions in general, and nasal sinus headaches in particular. It was during this hospital service that I first read some of Sluder's work, and met with disappointment in looking for material on the subject by other investigators.

One of the interesting things I noticed about purulent sinus infections was that the "cure" of

the suppuration did not always cure the headaches; and some cases with localized headaches, frontal, occipital, maxillary, parietal, etc. had no pus which could be demonstrated, but still had localized headaches almost identical with the pain in purulent sinus disease. The pain in these cases could be only neuralgia or neuritis since it follows the distribution area of certain nerves is usually intermittent, and no other cause could be found. When Sluder's "Nasal Neurology, Headaches, and Eye Disorders" came out it was a "key-to-the-scriptures" to me; and still is as far as the observations on symptoms, description of anatomical relations in the affected areas, and the discourse on pathology by Dr. Jonathon Wright in chapter one are concerned.

Classification of neuritides and neuralgias of the head is not altogether within the scope of the otolaryngologist. While it is my intention to discuss only the atypical neuritides or neuralgias, others will be mentioned for comparison only.

Neuritis and neuralgia are very often considered by physicians as synonymous; but writers of authority differentiate between them. The definition for neuralgia is, "paroxysms of acute pain in the distribution of a peripheral sensory nerve, no cause for which can be found." Neuritis is described as a nerve disease which is usually degenerative in nature and rarely accompanied by inflammation. To apply to neuritis in the nasal area this definition should be changed to the extent that usually there are no degenerative changes which can be described clinically, and complete recovery of the sensory nerves is almost invariable, and is attained in a large majority of the motor nerves.

The causes of neuritis are usually given in five categories: mechanical, vascular, infectious, toxic, and metabolic. Of course, neuritis in the nasal area

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could come under any one of these; but it is my intention to deal with the infectious type entirely, and especially the following three:

1. Vacuum frontal headache with eye symptoms only.

2. Anterior ethmoidal neuralgia (nasociliary).

3. The syndrome of nasal ganglion neurosis.

I should like to call all of these neuritis, since they fit in with the altered definition mentioned, and since I have proved to my own satisfaction that the cause of each of them is a non-purulent, nasal sinus infection. The vacuum frontal headache is described by Sluder as an unending headache of low grade without nasal symptoms, and is made worse on use of the eyes. He thought the pain was due to a partial vacuum resulting from absorption of the air which could not be replaced because of obstruction of the frontonasal duct. After a few years of experience with this condition I found that I could not agree with this theory. The strong point in deciding on the vacuum theory by Sluder and Ewing was tenderness over the floor of the frontal sinus, point of attachment of the pulley of the superior oblique muscle—the Ewing Sign. They attributed the pain due to excessive use of the eyes to tension on the floor of the frontal sinus from use of the superior oblique muscle. I could just as easily believe that pain is aggravated by tension on all the extraocular muscles. These muscles all arise from a fibrous ring around the optic nerve which is in close relation to the sphenoidal fissure and its important contents. The nasal nerve enters the orbit between the heads of the external rectus muscle and gives off the infratrochlea which passes under the pulley of the superior oblique muscle, while the supratrochlea nerve passes under the pulley. I could see tenderness at this point from the slightest inflammation or irritation of these two nerves. In my opinion the vacuum frontal headache belongs in the same category as the other neuritides under discussion and I shall discuss the etiology of all together. Obstruction of the frontonasal duct adds to the discomfort of these cases but the primary cause of this is nonpurulent sinusitis and rhinitis with a hyperplastic condition in the ethmoid cells and middle turbinates. The anterior ends of the middle turbinates are enlarged by thickening of the mucous membrane and vaso constrictors do very little toward shrinking them. However, I have seen many cases of this type headache which I believe to be truly vacuum. It follows an acute coryza by a few days or a few weeks and is relieved by one modified Proetz treatment and nasal decongestants. This type of case is very likely caused by obstruction of the nasofrontal duct by viscid discharge, the last bit of drainage from a mild acute frontal sinus infection. This, of course, is still an acute frontal sinus

infection, and could be due to a mild neuritis secondary to the recent sinus infection. However, I cannot believe this, since so little treatment is required to relieve it.

I expect some disagreement with my ideas in respect to the vacuum frontal headache, but less because of my statements in regard to the next item on the list—anterior ethmoid neuralgia—for the literature contains criticism of Sluder's conclusion on this. Harry Neivert² has said that this really should be included as a symptom of chronic rhinitis and sinusitis. This agrees with my conviction on etiology which I will discuss later. The pain is between the eyebrows and extends down the nose the extent of the nasal bones. The weight of glasses on the nose causes discomfort, but there are no eye symptoms. The anterior ethmoid nerve as it enters the nose is very near the surface of the membrane and receives a jolt with every inspiration. The inspired air strikes at the top of the meatus nasi communis so that the force and chill of the inspired air is more strongly felt at this point. Slight inflammation of this nerve or the membrane in its distribution area would cause discomfort.

Along with sphenopalatine neuralgia as described by Sluder, I shall include vidian neuralgia first described by Vail,³ and "atypical facial neuralgia" studied by H. Cushing,⁴ Foy,⁵ Reichert,⁶ and Glaser.⁷ These are classified by Wolf in his classical work "Headache" as cephalgias and atypical neuralgias. He considers them all allied to migraine in regard to mechanism of pain. The pain and its location, as given by several authorities, is so much the same in each of these cephalgias that the difference could be only in the disposition of each author. The symptoms which I have been able to find in the literature are pain over the root of the nose, and in the eyeballs and orbits—the maxillary zygomatic areas. The pain may extend to the mastoid with tenderness a few cm. behind the ear, and frequently to the shoulder and arm. The occipital region and the vertex are very commonly involved in the pain. From this one could see that any localized pain or tenderness about the head could indicate this syndrome. Pain or tenderness in the eyeballs is often the only pain area mentioned by the patient. Pain in the maxillary area and upper teeth is thought to be necessary for a diagnosis of nasal ganglion neuralgia, but I am convinced that it occurs in all degrees of severity, and that pain in any one of the above mentioned localities means the same entity. Some authors state that the nasal ganglion neurosis is a rare condition. To those who do not make a diagnosis of this condition unless the pain is very severe, it is found to be rather uncommon; but if we include the mild cases with one to three of the

above mentioned areas of pain, it proves to be one of the most common headaches.

What is called the sympathetic syndrome may occur either with the pain or at times when the pain is absent. It is generally thought by the patient to be a "fresh cold" because of the watery nasal discharge, sneezing, and burning sensation in the nose and roof of the mouth. It is accompanied by the same eye symptoms seen in coryza, hayfever, and other nasal conditions.

The psychogenic problem in the field of headache seems to be easy to discuss but difficult to solve. I agree with Ryan^s who says that he feels sure that there are far more pathologic headaches which are first thought to have psychogenic basis, than there are psychogenic and neurotic headaches first thought to have organic origin. I have found that almost all cases of nasal infection with headaches are "nervous," irritable, and apprehensive; and some cases have the trouble called "personality change." When the nasal pathology is controlled the psychic symptoms disappear. I have observed this in so many cases that I am forced to say that nasal sinus disease is one of the causes of nervousness and even of personality changes. However, lest I am misunderstood, I must add that I have also seen cases with psychic symptoms that were primary or due to other causes, since the control of nasal infection did not control the pain and nervousness. These cases are rather unusual and the pain is not localized. The pain in migraine may be localized to one side of the head, usually the upper half and, less often, the frontal and occipital region only. Tension headache is more confused with migraine than with the facial neuralgias. Rhinoscopy, history, and culture will greatly help in determining the correct diagnosis.

Since all of the above mentioned signs and symptoms can and do occur in acute nasal sinus infections following coryza, grippe, and influenza, it was my hope almost from the beginning of my experience in nasal diseases that I could prove to my own satisfaction that these facial neuralgias are usually caused by a chronic nasal sinus infection which produces very little or no pus. I have proved this to my own satisfaction by the following method: First, tampons of 5 per cent Ichthyol® in glycerin were placed in each meatus nasi communis for 15 minutes. The nasal chamber was then cleaned by spray with an alkaline solution. The next step was to apply gentle suction and examine the middle meatus for the presence of discharge. If any is present, it is picked up with a capillary tube for culture. By this method I have been able to secure a

pure culture of saphylococcus or streptococcus or a mixture of the two in almost all cases of definite facial neuralgia. Since then, Rosenau and others have proved beyond any doubt that infections of the nasal sinus lining membranes with streptococcus and/or staphylococcus without pus formation do exist and are very common. I believe it is not quite correct to call this nonpurulent infection. It is my opinion that all have an amount of mucopurulent material, although it may be extremely difficult to demonstrate and prove further than by culture. Discharge taken from the middle meatus or posterior wall of the nasal chamber may contain many more virulent bacteria per unit than when the quantity is measured by the cc. The maxillary sinus is frequently filled with purulent material which is found to be sterile on culture. The bacteria were viable only in the lining membrane and those thrown off by the discharge were destroyed by their own products of metabolism. The absence of pus does not rule out infection. If we are seeking the cause of affections like retrobulbar neuritis, any of the neuritides covered by this paper, or hyperplastic rhinitis, a culture should be made from the antral or sphenoidal washings, even if macroscopically clear, and also from any material obtained by the method described above. The culture must be made immediately. If left at room temperature or ice box temperature for hours, the results will not be accurate. Staphylococci multiply rapidly at room temperature and will obscure other bacteria in short order. Cold inhibits growth of streptococcus viridans much more than other varieties which may grow fairly well at refrigerator temperature. Sernenov⁹ states that in 80 per cent of cases there is a mixed infection of two or more organisms. Streptococci predominate in both swab and tissue culture, and staphylococci appear in 70 per cent. In my experience staphylococcus occurs in a very large percentage of cases. I must admit, however, that this is very likely due to improper handling of cultures, such as too long a time in incubator or too long a period in transit.

The Modern Conception of Headache

The modern conception of headache seems to point to a vascular dilation as the mechanism producing the pain in nasal neuralgias, as in migraine and tension headaches. In the case of sphenopalatine neuralgia the internal maxillary is thought to be the chief artery involved. This theory or conception of the mechanical cause of the pain will fit in with my claim that the fundamental cause of the nasal neuralgias is an infection or hyperplasia of the nasal sinus lining membrane and the mucous membrane of the nasal chambers; but it does not explain why cocaine will temporarily eliminate most of the

pain in nasal ganglion neuralgia, procaine injection around a tooth will stop headache caused by that tooth, and anesthesia of the cornea will stop headache caused by affections of the cornea.

The pain in the typical and atypical neuralgias and sinus infections occurs at all ages from early childhood to old age, and occurs in all degrees of severity. They range from the mild cases, which are not troublesome enough for the patient to go to the expense and inconvenience to have treatment, to those so severe as to make the diagnostician think of a major neuralgia. As would be expected, the more severe pain usually occurs in patients past 50 in the non-purulent cases, and from 20 to 40 in the purulent cases. In the purulent cases it is a well known fact that more severe pain is seen in cases with less purulent discharge. If a patient under 40 presents himself at my office with severe localized headache, I first suspect acute nasal sinus infection with pus formation; but in a certain percentage of cases it has been difficult to find pus in quantity although signs of acute inflammation are present. These cases I believe to be acute exacerbations of a chronic nonpurulent nasal sinus disease. Very small amounts of purulent material can be found in such a case and the culture will show one or more of the pus forming cocci. Large flakes of mucopurulent material can be found by irrigation of an apparently clear maxillary or sphenoid sinus.

Treatment

The first treatment to be mentioned is the submucous resection of the nasal septum. The curved septum, or spurs and ridges which may contact the turbinates with a very small amount of swelling of the mucous membrane, furnishes the temperature, moisture, and protection which favor the propagation of bacteria, as well as the retention and absorption of allergens from the inspired air. The submucous resection is just as important to correct conditions in the wide nasal chamber as in the narrow. On the concave side the turbinates hypertrophy to fill the abnormally large space. On this account the turbinate is found to be crowded into the sinus openings to the end that purulent sinus infections are more common and more severe on this side. In the case of nonpurulent infections, the pain is usually worse on the convex side. The submucous resection will almost invariably relieve the pain on the convex side if it is followed up by local treatment of the obscure infection. Many cases, for a few weeks, will complain of pain on the side having more space in the nasal chamber. There is good reason for this. When the septum is returned to the center between the meatus nasi communis there is contact between the septum and the hypertrophied turbinates which formerly

filled the septal concavity. This condition is easily corrected by a little time and local treatment.

The infection and hyperplasia are cured or kept under control by modified Proetz treatment, electrocoagulation, zinc ionization, and/or autogenous vaccine. The modified Proetz treatment is given as follows: Instead of the recumbant position with the head back, the patient sits in a treatment chair; small tampons containing the chosen medicament are placed under the middle turbinates, and larger tampons in the meatus nasi communis. When the tampons have been in 10 to 20 minutes, gentle suction is applied before or after the tampons are removed. Sufficient medication is left in the mucous coating lining the nasal cavities and is drawn into the sinus cavities after the air in the sinuses is rarefied by the suction. The air can be heard to rush into the cavities. This is evinced by a high pitched, somewhat prolonged whistle or squeak. I find that this method is much more acceptable to patients than that originally advocated by Proetz, and is very effective treatment for all types of nasal headache including the minor neuralgias. To do away with most of the discomfort caused by putting in the tampons, a very little topical anesthetic can be used to advantage. The lower turbinates can be remarkably reduced in size by electrocoagulation, and the middle turbinate can be removed if a few weeks Proetz treatment does not reduce it satisfactorily. The suction is apt to cause some headache in a large percentage of cases, and rarely will a severe headache result from it. The best prevention for this is the inhalation of a small amount of trichlorethylene immediately before the treatment. Zinc ionization in conjunction with the vaccine and Proetz treatment is good, but the severe reaction which lasts a few days is very undesirable. I prefer to give the displacement treatment a thorough trial if months are required.

The culture for autogenous vaccine must be taken as set forth previously, and culture incubated immediately for 24 hours. If allowed to stand at room temperature or incubated too long, the result will not be accurate. Staphylococci will grow so rapidly as to completely obscure and eliminate the streptococci and possibly others. I prefer to make the vaccine very potent and determine the desirable strength by cloudiness of the suspension. Accurate count is not necessary. The proper sterilization of the suspension is very important. 60°C for 45 minutes in the water bath has never failed me in sterilizing the vaccine. I have not noticed any added benefit in giving the vaccine intradermally, consequently I give it subcutaneously in increasing doses three times weekly, except in patients who are very sensitive to it. For these cases I prepare a special

SLUDER'S HEADACHE / Thomas

dilution and give it daily in increasing doses until the sensitivity is overcome, proceed with the tri-weekly dose, then weekly doses for a while. In the recalcitrant cases the vaccine can be used to advantage at monthly intervals indefinitely. Trichlorethylene by inhalation and daily injections of B₁₂ are very helpful as palliative treatment.

Summary

After close study of cases of localized pain in the face and head, I am convinced that the nasal neuralgias are almost always caused by nonpurulent rhinitis and nasal sinusitis, even if there is little or no hyperplasia of the soft tissues. Nasal sinus infection and rhinitis due to staphylococcus and/or streptococcus may run a chronic course with little or no pus formation. Mildness or severity of the pain is unimportant in making a diagnosis, in the neuralgias covered by this paper. Some are equally as disabling as tic douloureux. If treatment fails, look for a change in diagnosis of a mixed type of head-

ache such as psychogenic or tension type. Another thing to look for in case treatment fails to improve the neuralgia is to re-examine the septum for a spur or ridge which has been overlooked. When a septum operation is needed the results are most gratifying.

1616 Reynolds St.

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SURVEY ON MEDICAL SCHOOLS

The American Medical Education Foundation raised \$984,787 from physicians for medical schools in 1957. The National Fund for Medical Education, which receives its money from industry, contributed \$3,078,825 to the medical schools in January, 1958.

The median annual cost of medical school to a student, including tuition, minimum board, room, and supplies, in a private institution was \$1,958. In a state-owned school, the cost was \$1,395 to a resident of the state and \$1,731 to a non-resident.

The median amount of money spent by a four-year school during 1957-58 was between 2.3 and 2.4 million dollars.

The survey of medical schools this year showed that only seven—all state-owned—limited their first-year enrollment to residents of the state in which the school was located. This is a drop of five schools from the preceding year.

However, the publicly owned schools had only four to nine per cent of their students from outside the state in which each school was located. As a

consequence, the publicly owned schools had only one fourth to one fifth as many applicants as did privately owned schools, the report said.

Although the proportion of the total entering classes enrolled in each kind of school was about equal, the number of students lost to medicine by poor scholarship during the first year was significantly larger in each of the past four years in publicly owned schools.

The report said the problem is that their geographic restrictions on residence limit applications by and choice of as many highly capable students on the part of publicly owned schools as are turned away by the geographically non-restrictive privately owned schools.

The report expressed the hope that state legislators and other public officials concerned with these matters will cooperate with university and medical school administrators "in bringing the policies restricting admissions into a more realistic and socially useful focus."

SURGICAL TREATMENT OF SHOCK IN SEVERE INDUSTRIAL INJURIES AND WAR WOUNDS

*Maintenance of an adequate blood volume
is the primary consideration in approaching this problem.*

James E. Thompson, M.D., *New York, New York*

THE SURGEON'S MOST valuable asset in the treatment of traumatic shock is a thorough knowledge of the factors that can produce it. The immediate recognition of these factors enables him to take prompt measures to remove them. There are certain types of wounds common in industry and others that are more frequent in the war casualty; but as an important phase of each, shock represents the common denominator.

The typical case of traumatic shock should not be difficult to recognize. There is usually some gross evidence of trauma, the patient shows pallor, the skin is cool and moist, and the pulse is thready. The respirations are shallow; and the blood pressure readings, both systolic and diastolic, are low and sometimes barely detectable. There is often marked restlessness; and though the mind may be quite clear, there is a fortunate numbness to both pain and fear of death.

It is easy enough to recognize the classical picture, but we must be on our constant guard for the border-line patient who may be plunged into an irreversible phase by injudicious or hasty treatment. It is important, therefore, to pay careful attention to the early treatment which, above all, should entail a most careful preliminary examination in order to arrive at the conclusion that shock *does* exist. Consideration should be given to the differential diagnosis of shock, which is of particular importance in

civilian and industrial injuries. Coronary occlusion, cardiac failure, and pulmonary embolism are conditions that can present an identical picture. Any one of these complications of constitutional disease can initiate an accident, or be precipitated by the trauma.

Cause of Shock

The first part of my discussion will deal with the most frequent cause of shock, which is a reduction of the circulating blood volume brought on by hemorrhage. The hemorrhage may be external, from damaged blood vessels of fractured bones, or concealed within the peritoneal or pleural cavity. The sucking chest wound, so often seen in war casualties, and the obstructed airway are factors that accentuate the shock and must be cared for first, before any extensive attempts at surgery are made in the effort to control hemorrhage.

External Hemorrhage

Where the main blood supply to an injured extremity is intact, the function of hands and feet remains unimpaired, provided nerves have not been severed. Under these circumstances, it is safe to ligate obvious bleeding vessels, apply a pressure dressing and splint fractures as a temporary measure of control. However, massive hemorrhage from a wounded extremity, associated with a paralyzed foot or hand, means interruption of the major arterial supply until proved otherwise. Where feasible, such an injury requires rapid control of the shock, and an early attempt at repair of blood vessels.

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In case of complete traumatic amputation, ligation of all bleeders should immediately be done; but where the amputation is incomplete, a tourniquet may be used temporarily in the hope that restoration of damaged main arterial trunks will be possible. The control of extensive external bleeding from areas other than the extremities usually requires no more than a direct approach to the involved area with ligation of the bleeding vessels. In certain situations, such as when penetrating head and neck wounds are present, the control of hemorrhage may present a difficult technical problem. It is to be remembered that inaccessible bleeding in the maxillary or nasopharyngeal region can often be checked by the ligation of one or, if necessary, both external carotid arteries. Superior mediastinal hemorrhage may require a sternal splitting incision in order to control the bleeding; while penetrating wounds of the perineum causing hemorrhage from the lower portion of the rectum may be amenable to ligation of one or both hypogastric vessels, if packing has been ineffectual.

Concealed Hemorrhage

Concealed hemorrhage, however, presents a much more challenging problem; for not only is recognition of the bleeding of vital importance but its control must be accomplished without too much danger to the patient. It is relatively safe to assume that if a head injury shows evidence of shock, the cause must lie elsewhere. The typical patient with a sub-dural hemorrhage or brain laceration presents a picture that is, as a rule, the antithesis of shock; hence, for all practical purposes, attention should be focused on the thoracic and peritoneal cavities in looking for concealed hemorrhage.

Concealed hemorrhage within the thoracic cavity, though capable in itself of producing shock, is seldom an indication for an emergency open thoracotomy. The usual cause of such bleeding is the division, or tear, of the branches of an inter-costal or

internal mammary vessel. This type of hemorrhage is usually self-limited, and with the aid of one or more aspirations the blood can be completely removed and the lung kept expanded. If the blood re-accumulates after repeated aspirations, an exploratory thoracotomy is indicated in order to expose the source and control the bleeding. The ultimate aim is to evacuate all the blood before organization occurs, and thus make unnecessary a later operation to decorticate the lung. The diagnosis is suggested by the physical signs and is established by X-ray examination and thoracentesis.

Laceration of the lung, which sometimes occurs as the result of an associated rib fracture, may result in an associated tension pneumothorax. This development may be suggested by subcutaneous emphysema and marked deviation of the trachea to the opposite side. The picture is one associated with great respiratory distress and anxiety, and until it is remedied, little can be done to control the shock. Treatment consists of inserting a catheter in the second interspace anteriorly and connecting it with an underwater seal. If necessary, an additional catheter is similarly placed in the seventh or eighth interspace in the posterior axillary line, in order to maintain expansion of the lung and to keep the pleural cavity empty of accumulated blood.

Penetrating chest injuries, more generally seen in wartime due to the explosive effect of shell fragments, may result in "sucking wounds" that have a great tendency to produce a tension pneumothorax. In these patients, the wound must be temporarily closed and sealed with a pressure adhesive dressing before proceeding to relieve the tension and keep the lung expanded. Once the shock is under control, this type of casualty requires at least debridement and closure of the wound; and often exploratory thoracotomy is also indicated. A patient in severe shock will not tolerate extensive surgery until the altered pulmonary mechanics have been remedied. Therefore, in individuals with extensive bodily injuries, attention to the chest problem is of primary importance. Hemorrhage from a



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damaged thoracic aorta, its main branches, and from the major pulmonary vessels is rarely encountered as a clinical problem, undoubtedly because such severe trauma is associated with rapid death.

Concealed intra-abdominal hemorrhage is perhaps the most frequent cause of traumatic shock. The lack of pain and local tenderness exhibited by many patients often obscures the picture so frequently associated with the "acute" abdomen. Involuntary muscle spasm may be absent, or very slight, and the only evidence of blood within the abdomen may be "shifting dullness" elicited by percussion. Hemorrhage in non-penetrating traumatic injury is most likely to come from lacerations or tears of the spleen, liver, or kidney. Trauma may also produce tears involving other abdominal viscera that can lead to bleeding of some magnitude. Penetrating wounds will naturally involve anything in the course of the missile, so that it is important, where possible, to outline the path taken by the penetrating object.

Equally potent as a shock-producing mechanism is contamination of the pleural and peritoneal cavities by visceral contents. As abdominal trauma so often results in both hemorrhage and visceral disruption that diagnosis of one of these conditions automatically implies the probability that both will have to be treated. When damage to the stomach or intestinal tract is suspected, X-ray films of the abdomen may be of help in demonstrating free air beneath the diaphragm. Catheterization of the urinary bladder will usually reveal bloody urine, if damage to the kidney has occurred; and the presence of a torn bladder can be proven by failure to recover the amount of sterile fluid injected into it. A Levine tube placed in the stomach and put on suction is an important therapeutic measure for preventing aspiration of vomitus. The character of the aspirated contents may be of some significance. Any abdominal examination is incomplete unless a digital rectal palpation has been performed; and the presence of tenderness, pelvic masses, or blood on the examining finger may aid in understanding what transpires within the abdomen.

Combined thoraco-abdominal wounds are most frequently the result of penetrating missiles, and require the primary attention afforded to all chest injuries before the surgeon deals with the damage sustained in each of the two cavities.

An important cause of shock after industrial injuries, fortunately rare, is established clostridial myositis or gas gangrene. This type of infection must always be suspected and ruled out, when patients with extensive damage of the soft tissues develop delayed shock at some time, hours or days, after primary treatment of their injuries.

Severe burns may also cause profound shock, but are not discussed in this report.

Treatment

The first aim in the treatment of shock is to restore the circulating blood volume. While blood is being made available, this can be accomplished with dextran or plasma. These solutions should be used in a limited amount of no more than 1000 cc., as there is no real substitute for blood in dealing with shock.

In civilian practice, the blood should be cross-matched where possible. In the Korean war, however, group O, RH negative blood, low in titer for agglutinins A and B, was used. The administration of blood must be rapid and efficient. This often entails a "cut-down" on the vein to be used. The vein chosen should not drain into the area of damage. Occasionally, patients will require two "cut-downs," so that two transfusions can be given at the same time. We can now administer blood under pressure without the danger of air embolism by using the plastic container. Once the blood pressure has been restored to a safe level, immediate operation is necessary to correct the cause of shock. The patient in shock should be kept in a modified Trendelenburg position, with heat applied to the extremities during the period of preliminary treatment.

While blood is being administered, attention should be given to the measures previously mentioned, that is, temporary closure of "sucking-wounds," tracheotomy for the obstructed air-way and, where possible, control of external bleeding. A Levine tube should be put in the stomach and placed on constant suction, and antibiotics should be commenced. All wounds should be carefully inspected and dressed, and tetanus toxoid or antitoxin should be administered.

In non-penetrating wounds of the chest, operative intervention is mainly indicated for controlling hemorrhage that fails to respond to conservative measures. On rare occasions, surgery may be necessary for cardiac tamponade that has not spontaneously stabilized or not been relieved by needle aspiration. In penetrating wounds of the chest, on the other hand, exploratory thoracotomy is often required in order to repair damage to the lung, trachea, or esophagus. Injuries to the esophagus are particularly lethal when undiscovered and, therefore, not treated. When the wound extends through the diaphragm into the abdomen, extension of the thoracotomy incision onto the abdominal wall may be indicated. In some cases, a separate abdominal incision may be necessary.

In exploring the abdomen, to check hemorrhage and to repair damage to the stomach, intestines, and

other abdominal viscera, it would be helpful to keep the following points in mind:

1. A damaged spleen must always be removed.
2. It is wise to place packing in large lacerations of the liver, even though the major bleeding points can be controlled by transfixion sutures. The packed area, in addition, should be liberally drained.
3. The lesser peritoneal sac must be carefully explored in order to rule out injuries to the body and tail of the pancreas, as well as to the posterior surface of the stomach.
4. Special attention should be given to the extra-peritoneal portion of the second and third part of the duodenum; damage to these areas might evade cursory inspection and prove rapidly fatal.
5. A small bowel of doubtful viability should be resected.
6. In the presence of extensive fecal soiling of the peritoneal cavity from one or more large bowel perforations, a proximal colostomy should be performed after the damage is repaired.
7. A colostomy should always be performed as the primary treatment of penetrating wounds of the extra-peritoneal rectum.
8. After closure of tears in the urinary bladder, a suprapubic cystotomy should be accomplished with a reasonably large mushroom catheter. This is preferable to relying on a Foley catheter in the urethra that may fail to keep the bladder from becoming distended, as bleeding from mucosal damage some-

times results in large clots that block drainage from the catheter.

Conclusion

In conclusion, it may be stated that the major causes of severe traumatic shock are hemorrhage, fecal contamination of the peritoneal and pleural cavities, and extensive burns.

One additional cause of profound shock is clostridial myositis or gas gangrene which, though usually encountered in war wounds, fortunately develops only rarely after industrial injuries.

Less profound shock may develop after multiple fractures or extensive damage to the soft tissues. Persistence of shock under these circumstances may indicate an extensive loss of blood into soft tissue planes.

In the treatment of all forms of shock, the circulating blood volume must be restored and the blood pressure brought to a safe level before proceeding to remedy the cause by surgical means.

Unless relieved, an obstructed airway or a tension pneumothorax will defeat every effort to combat shock.

Only a thorough appreciation of these various factors will enable the surgeon to institute effective treatment.

Acknowledgment

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30 E. 72nd St.

THE DOCTOR GOES THROUGH

PERHAPS NO GROUP of professional people are more humanitarian than are the medical country doctors. What with the automobiles and paved roads, the rural doctor finds it out of the ordinary today to make his calls by any other method. But a few days ago, Dr. Orman Daniel used a conveyance that perhaps he has never before used in order to reach and relieve a sick woman. He traveled in a farm wagon.

The doctor motored out into the country a few days following the rain, sleet, and snow in answer to a call to a sick woman. At the end of the paving, he was met by the woman's husband with a wagon

drawn by mules. The weather was freezing cold and the muddy road was impassable for the car. Dr. Daniel mounted the wagon with his doctor's kit and rode for three miles. After ministering to Penny Williams, negress, he climbed again into the wagon and the two mules pulled the wagon over the three miles of wet, soft road. He got into his waiting car and returned to Jeffersonville.

Dr. Daniel was recently honored by the Men's Civic Club for his faithful services to humanity for more than a half century as a doctor in the profession of medicine.

—*Twiggs County New Era*

DORSAL STANDS FOR SPICA CAST

Waldo E. Floyd, Jr., M.D., *Atlanta*

An effective method for the prevention and treatment of presacral decubitus ulcers is described.

THIS SIMPLE APPARATUS is presented as a means of prevention and treatment of decubitus ulcers. It is essential to remove enough of the plaster cast posteriorly to prevent soilage at the time of defecation, when a patient is in a spica cast. Usually with the patient in the supine position, undue pressure is put on the presacral region, even when using a rubber inflated tube. It is necessary for the patient to be turned frequently in order to prevent the development of bedsores.

We have obtained good results in the prevention and treatment of presacral decubitus ulcers by building four stands on the dorsal aspect of the spica cast—two on the posterior iliac crest region and one on each posterior thigh region. The posterior iliac crests, costal margin, and heels are well padded. A large opening is made in the cast posteriorly over the buttocks. A yardstick is laid across each post to make sure that the buttocks will not touch the

bed when the patient is in the supine position. The post embodies the same principle as the old wash pot with stands. The stands can be made from one or two six inch plaster rolls which are folded when



Figure 1: Wash pot stands for dorsal side of spica cast. A small bed pan may be placed between the buttocks and the bed.

wet. Another roll of plaster is passed over this and around the trunk or extremity. The stands may be made high enough and far enough apart to place a bed pan between the buttocks and the mattress. The advantages of this procedure are: (1) it requires less turning of the patient, (2) it encourages healing by allowing air to circulate beneath the cast, (3) it prevents pressure on localized tissues, (4) linen and skin are kept constantly dry, and (5) it allows a large area of buttocks to be exposed for inspection and cleaning.

30 Boulevard, N.E.

Presented at the annual meeting of the Georgia Orthopedic Society, St. Simons Island, Georgia, September 21, 1957.
Note: The author is indebted to Dr. James Richards for the illustration.

The authors do not believe that there is any real evidence of an increase in coronary blood flow following this procedure.

LIGATION OF INTERNAL MAMMARY ARTERY IN TREATMENT OF ANGINA PECTORIS

IT WAS IN 1939 at the suggestion of Fieschi, in Italy, that Zoja and Cesa-Bianchi¹ first ligated the internal mammary artery on a patient for the purpose of increasing the flow to the myocardium. Following this, in 1955, Battezzati, Tagliaferro, and DeMarchi¹ reported the results of their anatomical and surgical research into this matter. They found after the injection of Methylene Blue and India ink near the level of the second intercostal space that they could obtain excellent mapping of the vascular network in the pericardium. Occasionally the dye was seen in the collateral circulation of the myocardium and epicardial fat pad.

On the basis of this report, Glover² and others in this country became interested in this work and did some experimental studies to confirm it. They also followed a large number of patients. Their results tend to show that there was a significant communication between the internal mammary and the coronary arterial systems. In addition to this, they felt that a significant number of dogs were protected from the effects of ligating the anterior descending coronary artery.

At the time of Glover's report in the *Journal of Thoracic Surgery*, 77 patients with arterio-sclerotic and hypertensive cardiovascular disease associated with angina pectoris had been subjected to bilateral internal mammary artery ligation. Fifty of these patients have been carefully followed from one to five months. Sixty-eight per cent of these patients have either lost the symptoms of pain or have been immeasurably relieved of their discomfort. The remainder were unimproved.

Anatomically it has been shown that the pericardiophrenic artery does anastomose with the vascular

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network within the parietal pericardium. It has also been shown that, when dye is injected into the internal mammary artery after ligation beyond the pericardiophrenic artery, the substance can be obtained from the coronary circulation. Figure 1 shows the schematic representation of the internal mammary arterial circulation which may be enhanced by ligation at the level of the second intercostal space.

There are some obvious defects that one can see in some of the assumptions which have been made in the past. In the first place, one cannot be certain that the ligation of an artery distal to its bifurcation will increase blood flow proximal to the ligated artery. For instance, studies have been done that show that if one ligates a single internal iliac artery, there is no measurable increase in blood flow into the contralateral leg. However, in this experiment one does not have the need for increased circulation that may be present within the myocardium of patients suffering from coronary insufficiency. Since the experimental proof of this type of treatment has been somewhat difficult to substantiate, it is even harder to completely evaluate its application to the clinical case.

The syndrome of pain associated with angina pectoris is so variable and protean in its manifestations, that complete evaluation is difficult in a great many clinical cases. The results obtained by any

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therapeutic measure in such a disease will by the nature of the process be difficult to evaluate. The associated psychic response of the individual to therapy is another difficult problem of assess. Certainly it is a well known fact that most patients that have angina have some degree of emotional overlay and, certainly, the very presence of such pain and the knowledge of heart disease, etc., will in itself produce a considerable emotional disturbance.

Report of Thirty Patients

This report deals with 30 patients who have had bilateral internal mammary artery ligation. All of these patients have been followed from one year to two months. The latest case included in this series has been done approximately two months ago. All of these patients have had the clinical diagnosis of angina pectoris made by competent medical men. They have all been followed by their respective physicians since the completion of the operation. In this group of 30 cases, there were no operative deaths. One case died five months post-operatively from an additional myocardial infarct. The youngest in this series is age 40 and the oldest age 81. The average of this group of patients is 59 years. There were 20 males and 10 females. Sixteen of the patients had had previous myocardial infarcts. All except one had evidence of coronary insufficiency and apparently had bonafide angina pectoris. One case was a questionable one in which there was disagreement in opinion as to whether this patient had angina. This individual received absolutely no benefit from the internal mammary artery ligation.

Fifteen of the patients had rather marked hypertension and there was apparently no difference in the results obtained in the group with hypertension and those with normal blood pressure. In an attempt to obtain an unbiased opinion as to the actual results of this operation, the patients were evaluated separately. The patients and physicians were questioned as to their feelings in regards to the benefit the patients had received, and we tried to evaluate each patient in the light of our own clinical judgement.

Recently, each physician was polled in regard to the present status of the patient. If the patient was completely free of angina under all conditions, it was considered an excellent result. If the relief was in the neighborhood of between 50 to 75 per cent, it was considered a good result. If the patient had received less than 50 per cent improvement, it was considered no benefit. It was felt that anything less than 50 per cent improvement could be well due to psychological improvement. These patients were all carefully told of the experimental nature of the procedure and that we had no real evidence that it

would be of any benefit to them. However, we did make it clear that it was an innocuous procedure and that it could be done safely. During the first six months of this study, we were indeed enthusiastic as a great number of patients began to show improvement. However, as the study progressed we could see that some of this improvement was not of a lasting benefit and that when certain factors were brought back into the patients environment, he began to have difficulty again. As time has passed, most of the patients have shown some progressive return to their angina.

Variability in Evaluation

It is because of this that one has to be very careful in the evaluation of any series in its early stages. Certainly this group of patients should be re-evaluated in another year in order to determine their longevity, as well as the duration of their relief. In studying this group, it was very interesting to note the variability in the physicians evaluation of the patient, our evaluation of the patient, and the patient's evaluation of his own results.

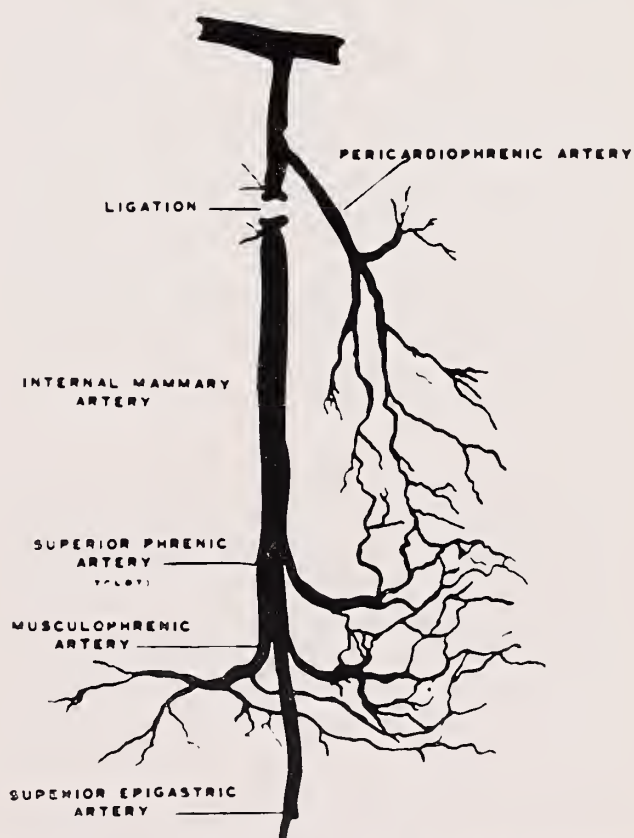


Figure 1: Schematic representation of the internal mammary arterial circulation which may be enhanced by ligation at the level of the second intercostal space. (Glover 2)

Of this group, seven cases were considered as having attained an excellent result by the physician. Eight cases were thought to be excellent from the

patient's standpoint. However, only one patient was in both of these groups. Patient number eight was classified as excellent by his physician, but no improvement was attained according to the patient's self evaluation.

There was a little closer relationship between the physician's evaluation of the patient than our own. In our own critical analysis of the patient, we tried to eliminate any patient who might have a potential of psychological overlay. This is very difficult to manage because the patient feels that he has had a surgical procedure in which something has been done to correct the trouble in his heart.

The very fact that he has been through a surgical operation gives him a considerable amount of relief. This feeling is very difficult to limit. In reviewing our statistics, it was found that 41 per cent of the patients received benefit in his own physician's eye, whereas from the patients view point, 67 per cent had received benefit (50 per cent or better). When we evaluated the patients individually, we felt that approximately 34 per cent of them had received some improvement. Actually, we felt that approximately 43 per cent of the patients had received benefit of 50 per cent or better, whereas the private physician thought only 41 per cent. This discrepancy has been difficult to completely understand unless one accepts the fact that there must be considerable amount of psychological improvement associated with the patient's response to this particular procedure. All except one of the patients are still alive. One patient died of a repeat coronary approximately five months after his operation.

Technique

All but three of these patients have been operated upon under local anesthesia. It is felt that if internal mammary artery ligation is used, it should always be done under local anesthesia. The patient is prepared with routine pre-operative sedation. An incision is made over the second intercostal space just lateral to the sternal border for a distance of about two inches. The internal mammary artery is identified as it lies just outside the pleura in the parasternal space. Several lymph nodes may be encountered in this area and may increase the difficulty of the dissection. Generally speaking, the arteries are easily identified and no particular difficulty has been encountered in any of our patients. Only one pleura was entered and this was under general anesthesia when the patient coughed in the middle of the dissection. No complications resulted. Many of the patients left the hospital the day after

surgery. The artery was doubly ligated with 00 silk, but not divided.

Summary

Bilateral internal mammary artery ligation has been done on 30 patients. These patients have been followed from a period of two months to a year. In evaluating these patients from the physicians' viewpoint and from the patients, there has been a very poor correlation. Only 41 per cent of the patients have received material benefit in the physicians' eye, whereas 67 per cent of the patients said they had materially improved. It is difficult to account for this discrepancy unless it is on the basis of psychological improvement. It is our opinion that there is no real indication that internal mammary artery ligation increases coronary circulation and that it should be used only in selected cases and under controlled circumstances. We do not advise it as a universal method of increasing coronary blood flow.

Six patients out of this group showed definite improvement in the EKG's following bilateral mammary artery ligation. These changes were mostly those of ischemia which cleared up after ligation. This, of course, is hard to evaluate as we know that patients with angina may show changes of ischemia from time to time which could clear up with or without treatment. Therefore, we do not feel that EKG changes can be used as proof of any real improvement. Of these six patients only two are in the group that were considered to show improvement from the internal mammary artery ligation.

The fact is that in evaluating all of the statistics and data, one comes to the conclusion that there can be no correlation on an objective basis of any improvement. After carefully following these patients, one is indeed impressed by the fact that they are a group who have been treated for long periods of time medically and that they are anxious for any form of benefit. They apparently are very eager to try anything that may give them relief from angina. Certainly we cannot escape the fact that a certain number of patients have received real benefit which cannot be explained on an emotional basis. This will have to be attributed to the effects of the operation. However, we do not believe there is any real evidence of an increase in coronary blood flow following the ligation of the internal mammary arteries.

In the treatment of angina and coronary artery insufficiency many operations have been devised in the past. We are all familiar with the work of Beck, Vineberg, O'Shaughnessy, and others who have attempted to increase coronary blood flow by various methods. In addition, certain groups have denervated the heart and have performed sympathetic nervous system surgery. All of these procedures

have met with various degrees of success, but have not been widely accepted. At the present time, in our estimation the surgical treatment of choice is the Beck I procedure with pericardial poudrage and partial coronary sinus ligation.

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1959 CALENDAR OF MEETINGS

State

- March 6-7—Georgia Society of Ophthalmology and Otolaryngology, Savannah.
- April 6-7—Augusta Graduate Assembly, Augusta.
- April 11-12—Atlanta Society of Pathologists, Atlanta.
- May 17-20—Medical Association of Georgia, Augusta.
- May 17—Georgia Pediatric Society, Augusta.
- May 17—Georgia Psychiatric Association, Augusta.
- May 17—Georgia OB-GYN Society, Augusta.
- May 17—Georgia Chapter, American College of Chest Physicians, Augusta.
- May 17—Georgia Radiological Society, Augusta.
- May 17—Georgia Diabetes Association, Augusta.
- Sept. 11-12—Georgia Heart Association, Atlanta.
- Sept. 18-19—Georgia Tuberculosis Association, Athens.
- Sept 18-19—Georgia Trudeau Society, Athens.
- Sept. 20—Georgia Psychiatric Association.
- Sept. 24-26—Georgia Chapter, American College of Surgeons, Sea Island.

Regional

- March 2-5—New Orleans Graduate Medical Assembly, New Orleans, La.
- March 9-12—Southeastern Surgical Congress, Miami Beach, Fla.
- Sept. 28-29—Tennessee Valley Medical Assembly, Chattanooga, Tenn..
- Nov. 14-17—Southern Medical Association, Atlanta.

National

- March 5-7—14th National Congress on Rural Health, Wichita, Kansas.
- March 15-20—American College of Allergists, San Francisco, Calif.
- April 2-4—Association of American Physicians and Surgeons, Ft. Worth, Texas.
- April 6-9—American Academy of General Practice, San Francisco, Calif.
- April 13-15—American Academy of Pediatrics, San Francisco, Calif.
- April 19—American Society of Internal Medicine, Chicago, Ill.
- April 20-24—American College of Physicians, Chicago, Ill.
- May 25-29—American College of Cardiology, Philadelphia, Penn.
- May 25-29—National Tuberculosis Association, Chicago, Ill.
- May 25-29—American Trudeau Society, Chicago, Ill.
- June 3-7—American College of Chest Physicians, Atlantic City, N. J.
- June 8-12—American Medical Association, Atlantic City, N. J.
- Aug. 30—American Congress of Physical Medicine and Rehabilitation, Minneapolis, Minn.
- Sept. 27 - Oct. 2—American College of Surgeons, Atlantic City, N. J.
- Sept. 14-17—International College of Surgeons, Chicago, Ill.
- Oct. 3-8—American Academy of Pediatrics, Chicago, Ill.
- Oct. 23-25—American Heart Association, Philadelphia, Penn.

CHRONIC VENOUS INSUFFICIENCY

P. C. Shea, Jr., M.D., *Atlanta*

MANIFESTATIONS OF POST-PHLEBITIC SEQUELAE (chronic venous insufficiency) occur in all age groups. Therefore, it may be observed in all aspects of the practice of medicine. Prominent features of venous insufficiency are seen in children, the result of septic phlebitis, and in youngsters following burns and scar contractures in the lower extremity. It appears in young and middle aged females, during and after pregnancy, and in the elderly as a result of either localized or massive venous occlusion. W. Andrew Dale has recently pointed out that with the development of freeway systems and prolonged periods of automobile driving, many will suffer from a syndrome, aptly described as "thruway thrombosis," which will produce post-phlebitic sequelae. Annually a number of patients are seen who require rehospitalization, reoperation, and grafting because the initial surgical attack has been inadequate or recurrences develop. No longer can the surgical approach to chronic venous insufficiency be considered a minor surgical procedure.

The Problem

When marked venous insufficiency or a fully developed post-phlebitic syndrome occurs, it is frequently economically disastrous. An individual is unable to remain gainfully employed and/or requires long-term hospitalization for rehabilitation. With the rather rapid increase of the elderly population more and more patients will present themselves, requiring equally more hours of care. Serious complications may result from long standing involvement. Septicemia, monilia infestation, carcinoma, and deformity and morbidity so great as to require amputation are known to occur. Efficient

early treatment of venous thrombosis is the best preventive measure, and in the post-thrombotic state prophylactic therapy and patient education in personal care are extremely important adjuncts. But, once existing, the care of the patient with chronic venous insufficiency is the responsibility of the surgeon, for it falls into the pattern of all disease a surgeon treats, namely; amelioration of infection and reconstruction.

The Syndrome

The post-thrombotic syndrome is characterized by the following changes in the usual order of their appearance:

1. pain
2. edema
3. varicose veins
4. stasis cellulitis
5. stasis dermatitis
6. pigmentation and eczema
7. chronic ulceration

In brief, these are aggravations, the result of chronic venous insufficiency. In addition other distressing (and sometimes hazardous) changes develop, such as:

1. infection
2. monilia infestation
3. osteoporosis of bones of the feet
4. muscular atrophy
5. post-phlebitic neuritis
6. pyemia; metastatic abscesses
7. gangrene

Pain

Pain, more often than not, is the patient's presenting complaint. It occurs for a number of reasons in chronic venous insufficiency and its char-

acter is varied. It may appear as a dull ache after prolonged standing or even to lesser extent after walking. The latter is due to congestion in leg muscle and increasing edema. This congestive type pain will disappear after 5-30 minutes of leg elevation, only to recur when the individual becomes upright again. Pain also occurs in those with ulcers, or cellulitis, due to the secondary inflammatory reaction. Occasionally, neuritis of the saphenous nerve will produce hyperesthesia which may be severe and paroxysmal. Classical intermittent claudication is a type of pain associated only with arterial ischemia. Careful interrogation is necessary to differentiate this entity from the pain of venous insufficiency. Unfortunately, in some patients both phenomenon exist.

Etiology and Pathogenesis

Homans observed the peak time for occurrence of ulceration to be two to five years after the development of deep venous thrombosis. Hojensgard reviewed 57 patients (1952) in whom deep thrombosis had occurred six to 31 years previously. In 89 unselected extremities in these patients, 87 per cent complained of heaviness and fatigue, 78 per cent had chronic edema, 27 per cent present or past ulcer, 45 per cent wore supporting bandages constantly.

High sustained venous pressure exists in the extremity because of incompetent valves in the deep, communicating and superficial systems of veins. This follows recanalization of thrombosed deep veins. Lymphedema then becomes apparent; and chronic venous insufficiency has developed. Most frequently it is preceded by ilio-femoral phlebitis, or on occasion repeated episodes of saphenous phlebitis. Basically, the problem is one of stasis of venous blood flow, either localized, or involving the entire extremity.

Thrombo-phlebitis will damage small venules and capillaries during the acute phase of the disease. Also, it may produce valve destruction or permanent venous obstruction. The damage that is present in acute phlebitis is markedly aggravated by the stasis produced in the upright position. The most dramatic changes in skin and subcutaneous tissue appear on the inner side of the lower third of the leg just above the internal malleolus. In this particular area communicating veins are more prone to incompetency because they pass through tendons, and lack the muscular support of communicators higher in the leg. Localized high venous pressure produces subcutaneous fat necrosis, with subsequent organization and plaque formation which may or may not ulcerate. Ulceration in such an area is usually caused by trauma, sometimes by infection.

Chronic venous insufficiency must be differentiated from the following states:

1. edema
2. edema, due to renal disease
3. lymphedema
4. arteriovenous fistula
5. changes due to arterial ischemia
6. myositis, scleroderma, abscess, etc.

In the presence of leg ulcers, numerous disease entities may have to be excluded, such as:

1. erythrocyanosis frigida
2. post-poliomyelitic ulceration
3. ulceration, due to trauma, or infection
4. ulcers due to underlying bone disease (Padgett's disease, osteomyelitis, etc)
5. pressure sores
6. ischemic ulcers
7. ulcers, associated with systemic disease (ulcerative colitis, syphilis, neoplasm, sicklemia, etc.)

Treatment

The most favorable defense against the problems posed by chronic venous insufficiency is adequate therapy of acute thrombophlebitis (and phlebotrombosis), and persistent attention to prophylactic measures including patient education in the immediate post-thrombotic period.

EDEMA:—existing alone is most satisfactorily managed by bed rest and lower extremity elevation. In addition, adequate supporting leg wrappings should be used. A well-fitting elastic stocking is preferred to elastic bandages and careful avoidance of constricting items of wearing apparel is recommended.

If edema and varicose veins exist, the varicosities are managed by the appropriate, indicated surgical procedure and the edema controlled with the aforementioned measures. If eczema or eczematoid changes are present, or when epidermophytosis exists, extra therapeutic means are available for proper care. A whole host of medicaments are produced, too numerous to mention, to which these latter entities respond. Caution is advised in the use of topical agents because the patient may exhibit a sensitivity reaction or develop one, magnifying the problem rather than reducing it. During the treatment of the skin lesions, however, one must not lose sight of the need for relieving the underlying defect.

CELLULITIS:—bed rest is essential for successful treatment, and frequently it is necessary to administer antibiotics systemically. It is interesting, however, to note the marked resolution of a low-grade cellulitis on bed rest alone without additional treatment. At the time a patient requires this type of therapy, a planned and timely program for sur-

gical correction of the basic difficulty must be developed. When weight bearing or the upright position is assumed after a bout of cellulitis, elastic stockings are an important adjunct.

ULCERATION:—treatment of the post-phlebotic, ulcerated leg varies considerably depending on the size, chronicity, and amount of infection demonstrated in the ulcer. To a greater degree, it may be prolonged if other changes (marked lymphatic obstruction, chronic induration, etc.) have been present for a long period of time. The overall aim in management is the reduction of swelling, initiation of healing (or grafting the skin defect), and surgical correction of the underlying venous defects.

There is little doubt that bed rest, with leg elevation, is a most effective means in the reduction of swelling and promoting the ability of skin to re-epithelialize the defect where the ulcer exists. Leg elevation of four to five inches above the horizontal will increase the venous emptying time of the leg some threefold. In addition, it produces an increased outflow from congested lymphatics. The most efficient device for elevation is to place bricks or blocks, five inches in height, under the front legs of the bed. This method avoids any jack-knife effect at major joint areas (which in itself is obstructive). This type of elevation also results in an evenly distributed, flat, firm surface and avoids pressure areas that pillows, rolled blankets, etc., may give. Its use is particularly effective also in the patient with edema alone, for it guarantees seven to eight hours of elevation each night while he is asleep. With elevation and bed rest an amazing amount of healing will occur.

Where a large amount of necrotic material is present in the ulcer area, varied debridement techniques are used to restore a good, clean, granulating base. This may be accomplished by surgical, enzymatic, or simply mechanical means with saline soaks and frequent dressing changes. Most frequently the saline compress dressing changed three times daily, along with PhisoHex® scrubs (by the patient, five minutes twice daily) have proved satisfactory in cleaning up a dirty leg ulcer and readying it for grafting. However, when the ulcer bed is hard, bloodless, and discolored grayish white it will require surgical excision.

Innumerable surgical procedures are designed to relieve disability present in the leg with venous insufficiency. Fundamentally, the basic theme is to correct the deformity in the saphenous system, control incompetent communicating veins, and heal the ulcer. In the past several years a few procedures have proved to have great merit. One described by

Moyer et al consists of ligation, excision and stripping of varicies, and simultaneously excising the ulcer and all thickened fascia about it. An immediate thick, split-thickness skin graft is applied to the defect. Dodd and Cockett similarly manage the saphenous system, but approach the communicators in the lower portion of the leg by a linear incision, one inch medial to the border of the tibia and directed toward the upper margin of the medial malleolus. If the skin and subcutaneous tissue are not badly damaged, the communicating veins are attacked in a subcutaneous plane. If tissue damage is excessive and viability in regard to healing questionable, these communicating veins are reached through a subfascial approach. If the ulcer still exists, they prefer to incorporate and excise it within limits of this incision, but to delay grafting until suitable fresh granulations appear. If communicating veins exist laterally, and especially when a marked collateral exists with the external saphenous system, a similar linear approach can be carried out on that side of the leg and the external saphenous can be reached and stripped through the same incision.

The so-called "stocking seam" approach has been developed by Felder et al. This enables the surgeon to approach the communicating veins through a medially placed incision in the posterior portion of the leg; the incision in its linear axis corresponding with the seam of a woman's stocking. This latter procedure is preferred by some surgeons because it not only incorporates a direct approach to all troublesome, communicating veins in the lower leg, but there is less opportunity for wound breakdown and loss of viability from interrupted blood supply as occasionally presents in the laterally and medially placed incisions.

Other Considerations

OBESITY:—A proper weight reduction program is an essential component of adequate treatment. There is no doubt that in the overweight individual the problem of fat necrosis, lymphedema, etc., are magnified and much more satisfactory results are obtained when obesity is corrected.

MAJOR VENOUS INTERRUPTION:—Long term studies on patients in whom superficial femoral and/or popliteal veins have been divided and ligated fail to show any advantage of this procedure. Even where major veins are little more than a hollow tube they add to rapidity of venous emptying and reduction of lymphedema when elevation of the leg is a component of therapy.

LUMBAR SYMPATHECTOMY:—Follow up studies on patients who have a post-thrombotic syndrome with swelling and tissue changes reveal that swelling is increased after sympathectomy and that this operation usually hinders rather than assists in

the recovery program. Acute experiments in post-phlebotic legs both before and after sympathetic block demonstrated that arterial vasodilatation made walking less effective in lowering peripheral venous pressure (Edwards). This was thought to explain the increased edema often noticed in warm weather and in some post-thrombotic extremities after sympathectomy.

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SECTION OF THE PITUITARY STALK IN DIABETES MELLITUS

Staff of the Medical College of Georgia, *Augusta*

*Dr. Owen (Medicine):**

Today we're going to discuss a patient who is not present. He was discharged last Saturday but Dr. Abels will present the case in absentia.

Dr. Abels (Intern):

The patient for today is J. C., a 24 year old white male, who was referred into this hospital with the diagnosis of diabetes mellitus, diabetic retinopathy, and Kimmelstiel-Wilson's disease. His history dates back to the age of nine when symptoms of diabetes mellitus appeared. He has never been under particularly good dietary control since then, but at the time of admission to this hospital was fairly well controlled by 40 units of lente insulin and ten units of regular insulin a day. Trouble with his eyes dates back to November, 1956 when he noted black streaks in the visual field of his left eye. Several weeks thereafter, he had sudden loss of vision in this eye and was told that this was due to hemorrhage. In a period of five months the vision gradually returned in this eye but it was still somewhat blurred. Six months later he had another hemorrhage in his left eye which left him able to distinguish only light and dark. Approximately two months prior to his admission here, he began noticing the same symptoms in his right eye, and was told again that he had more hemorrhages. *Past history is non-contributory. Family history is nega-*

tive for diabetes. Physical examination here showed the vital signs to be within normal limits and positive physical findings were limited to the examination of the eyegrounds. The left eye had no red reflex or light reflex, and the left retina could not be visualized. The right eye showed numerous retinal scars, exudates, and small hemorrhages. The vessels were tortuous and somewhat sclerotic. Pupillary reactions were normal. *Laboratory data:* The blood count and chest X-ray were normal. The urine contained a small amount of protein but renal function was adequate as evidenced by a PSP excretion rate of 47 per cent and a normal BUN. The rate of radioactive iodine uptake was normal as were the excretion rates of 17-hydroxy and 17-ketosteroids. The existence of diabetes mellitus was proved by a fasting blood sugar value of 280 mgm. per cent and a 3+ glycosuria. *Clinical course*—The stalk of the pituitary was sectioned on February 28, 1958. Prior to surgery he was prepared with large doses of Cortisone®, and the operation was carried out without difficulty. Immediately following surgery he was maintained on infusions of insulin and glucose. He was also given large doses of Cortisone® and watched very closely for the development of diabetes insipidus which did appear on the same day of surgery. For this he was given aqueous Pitressin®, 10 units q four hours. He did rather well post-operatively except that the diabetes mellitus was very difficult to control. At first he was given insulin on a sliding scale but continued to run 3+ and 4+ urine sugars before every meal and at bed-

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**Dr. John A. Owen is now at the VA Hospital in Washington, D. C.*

time. He was, therefore, started on *lente insulin* and the dosage was gradually increased to 35 units daily at the time of his discharge. The Cortisone® dosage was gradually decreased to 12.5 mgm. t.i.d. The blood counts and serum electrolyte concentrations following surgery were within normal limits. The urinary steroid excretion following surgery was somewhat depressed and there was no significant change in the rate of radio-active iodine uptake. The BUN remained unchanged. He was discharged from the hospital on 35 units of *lente insulin* every-day, 12.5 mgm. Cortisone® t.i.d. and given Testosterone® pellet implantation the day prior to his dismissal.

Dr. Owen:

Thank you, Dr. Abels. There have been considerable changes of opinion in the treatment and handling of the diabetic in the last 35 years, which takes us back to the first time that insulin was used therapeutically, when it was felt that this was an answer to all problems regarding diabetes; that by substituting for the patient's endogenous insulin production, a daily injection or several daily injections, the diabetic patient could live a long and happy life as unencumbered by complications as, say, a patient with myxedema. Nine years later in 1931, Houssay and Biosotti in Argentina reported that simultaneous removal of the pancreas and the anterior pituitary from an animal resulted in a diabetes which was quite mild. This was called the Houssay effect. Obviously, this rather radical attempt to modify pancreatic diabetes by a hypophysectomy did not create a tremendous interest among clinicians because they already had the answer—they had insulin. But as years went by it appeared that there were many patients whose insulin was not enough to keep them from developing a steadily increasing number of complications. These complications are statistically correlated with poor control of the diabetes, but they do happen in patients who do their utmost to follow every regime which has been instituted by their physicians, and there are patients who disregard all instructions and don't get these complications. There's something different about replacement therapy with insulin and the patient's own endogenous insulin supply. These complications then are becoming more and more troublesome to the clinician, particularly since no adequate pathophysiological explanation is evident and since no good therapeutic approach seems obvious. We have gone down a variety of avenues looking for the answer.

Now the first avenue, I think, might have been suggested by one single patient. This patient was reported from Denmark in January, 1953 and her story is rather interesting. She was born in 1915,

and developed diabetes at the age of nine. She didn't take very good care of herself, and during the next 15 to 20 years she had approximately 20 episodes of diabetic coma. In 1944, at the age of 29, she noted decreasing vision, and in March, 1945 became pregnant. In September, six months pregnant, she was seen by an ophthalmologist for the first time, and he described postcortical cataracts and diabetic retinopathy bilaterally, consisting of numerous hemorrhages all over the retina. On December 10th she delivered a dead fetus and nine days later had a severe postpartum hemorrhage. Then appeared the sequence of events that always occurs in Sheehan's syndrome. There was failure of the breasts to become engorged, amenorrhea, loss of libido, increased cold sensitivity, episodes of weakness suggesting hypoglycemia, and increasing sensitivity to her insulin which she had to decrease to half the previous dosage. In the middle of 1949, without having received any particular treatment for her hypopituitarism, it was found that the retinopathy was now reduced to just a few scattered hemorrhages and exudates, a very marked and obvious change. In March, 1951 she was thoroughly worked up and started on treatment, and by that time the diabetic retinopathy had completely disappeared. The cataracts were unchanged, and even though she has been kept on a maintenance therapy, within the two years following the institution of this therapy, her retinopathy was still completely gone. In this article, the author cites eight previous cases, but none of them described definite retinopathy to begin with or were able to follow it after the development of hypopituitarism. So, I think, this is really the first good case which illustrates Houssay Phenomenon in man with complete reversal of diabetic retinopathy.

This case, I like to think, was the inspiration to the group in Stockholm to begin performing therapeutic hypophysectomies in patients with diabetic complications. They have done this since 1949 or 1950, and in their last report (April, 1956) they described 20 cases (10 males, 10 females) all of whom had albuminuria and retinopathy. These patients all presented a problem of advancing complications in a fairly well-controlled young diabetic; none of whom were older than 33. As a result of hypophysectomy seven of the 20 died within the next 19 months. Some died postoperatively; some went on downhill and died of advancing renal disease; some had wide erratic fluctuations in their carbohydrate metabolism that seemed to be the cause of death. Of the remaining 13, all showed a decrease in the albuminuria, a fall in the elevated blood pressures, no particular change in renal plasma flow, and a tendency to a decrease in the glom-

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erular filtration rate. The eyes were followed closely, in ten of the 13 patients, and one became worse. In the other nine only three were found to show any fresh retinal hemorrhages, and five showed improvement in visual acuity and decrease in new vessel formation.

Because this report came out in 1956, and we've heard nothing since, I wrote to Dr. Luft in Stockholm several weeks ago, asking him what his conclusions at the present time were with regard to the value of this operation. He replied that he felt that many of the patients in the original series had been operated on with too-far advanced renal disease; these patients were not able to live long enough to show any response to hypophysectomy and he didn't plan to operate on any more who showed elevated NPN's or decreased clearance values. He said that he had not operated on any patients since the original 20 because he wanted to follow them closely in order to evaluate the procedure. He felt that the operation still has therapeutic possibilities with better selection of patients and he intends to resume doing this procedure this fall.

Now it might be worth while to sidetrack for a moment and describe very briefly, the complications that can occur in diabetics and, as I've said, these seem to have a definite relationship to the lack of good control of the diabetes. They are more common in juvenile diabetes and they rarely appear until the patient has had the disease for 13 or 14 years. After that they increase in frequency in proportion to the lack of good control.

The three most common lesions are neuropathy, retinopathy, and nephropathy, and it would be indeed tempting to say that all of these have a common pathological basis. Certainly there is no good argument against those who feel that there is a vascular basis for the renal disease and the retinopathy and although the neuropathy hasn't been as well studied, I think there's evidence that this is also on a basis of impairment of the circulation to the nerve trunks. What causes this disturbance in the vessels? It appears to be the deposition of a hyaline material within the arterial wall or within the capillary wall, and whether this begins from the endothelium and progresses inwardly or whether it is a foreign substance which is deposited there, I don't think anybody knows. This substance does have many biochemical properties suggesting mucopolysaccharide and some of the chemical constituents of mucopolysaccharides are sensitive or, let's say, susceptible to the action of insulin, and appear to have their metabolism affected by insulin. It may be that when we better understand the effects of insulin on

mucopolysaccharide metabolism, we'll have the answer to these complications.

As far as the young diabetic is concerned, his first clinical symptom is usually a decrease in vision as our patient today has shown. This reveals itself to the ophthalmologist as retinal hemorrhages beginning as capillary aneurysms which gradually become flame shaped, more extensive, often involving the vitreous humor, and associated with exudate formation and new vessel formation, which constitutes the picture called retinitis proliferans. No patient who has reached the stage of retinitis proliferans has ever had a spontaneous reversal of his eye disease. After retinitis proliferans one often gets contraction of the scars extending out into the vitreous with retinal detachment, glaucoma, and complete loss of vision. Dr. Fair, who has been extremely interested in this problem, unfortunately is not present today, but he's asked Dr. Kimmerling if he would show a few slides in regard to the retinopathy. Our patient today came to Dr. Fair with a much worse picture than you saw on these slides, and Dr. Fair sent him to me. We discussed the situation as I have discussed it with you—pointing out to him the experimental nature of this approach and the percentage of successes and failures that have been attained previously. Then, I sent him down to see Dr. Smith to talk about the technical details of the operations. I'd like to ask Dr. Smith if he would tell us what operation he does, why he does it, instead of hypophysectomy, what sort of experiences he's had with it, and what he thinks it accomplishes.

Dr. Smith (Neurosurgery):

The original work with the hypophysis in relationship to the treatment of diabetes mellitus in the so-called malignant or insulin resistant cases was pioneered by Olivecrona and Luft. The original hypophysectomy therapeutically performed in man, however, was performed in the country by a Dr. Earl Walker. The matter of the technique and whether or not a complete hypophysectomy is mandatory or whether interrupting the blood supply with infarction of the adenohypophysis, by merely doing a stalk section, I think is still in a period of investigation. The procedure I've been doing here is one of cutting the pituitary stalk in its lower third, approximately 2 mm. from the diaphragm sella. The therapeutic action of section of the pituitary stalk is much the same as occurs in Sheehan's disease, the observation that first inspired such an approach. Stalk section merely infarcts the gland and also interrupts the neural pathways from the posterior lobe to the hypothalamus. The greatest change, however, is to interrupt the portal circulation which is made up of the superior and inferior hypophyseal

arteries which anastomose freely and pour their blood into the sinusoids of the anterior lobe. By interrupting this flow, thrombosing the vessels, and infarcting the gland, a hypopituitary state results as is seen with complete ablation, either surgically or by X-ray means. In this particular group of cases of which we are speaking, namely the malignant diabetic group, their vessels are notoriously poor, and I think that the surgical risk involved is probably greater when one is entertaining the matter of complete ablation of the gland. The simple matter of interrupting the stalk, I believe, is an advantage operative-wise when dealing with such a poor risk patient. An interesting postoperative feature is the appearance and then the disappearance of diabetes insipidus. The diabetes insipidus is apparent the first few days following the procedure and then we note that the water intake and output seems to balance off. Dr. Owen may shed some light on this. Another point I hope that he will shed some light on is the matter of the follicle stimulating hormone being present in the stalk section and also in those patients who had complete ablation of the adenohypophysis, and the posterior lobe. The matter of whether or not the retinopathy improves post-operatively requires considerable observation and long term follow up. It would seem difficult to me to see how the retinopathy could actually improve. I can see how the process could be arrested, but it's a little difficult to understand how the changes that are already in the fundus as evidenced by photographs would actually change. Although, Olivecrona and Luft are very definite in their statements and reports that their patients do show an improvement in the fundus picture and visual acuity. It is common that following posterior chamber hemorrhages there is a waxing and waning of vision, and I could see how subjective improvement in vision might be present but not the objective improvement in a patient with advanced retinopathy. The chances of getting a good surgical result would be much less, regardless of whether you use stalk section or complete ablation. I hope I've answered the questions that you had in mind. I wonder whether or not the matter of removing the growth factor would reduce the amount of lipid tissue that might be produced in the new formed vessels than in new vessels, and whether or not actually the interruption of the growth factor might not be a factor in not only making the patient more insulin sensitive but stopping the vessel changes as well.

Dr. Owen:

I think that's a good point, and the loss of growth hormone probably does have some effect. Its significance will have to await more thorough knowledge of exactly what the growth hormone does to diabetic

complications. We have used this approach not only in patients with diabetes, but also with patients with metastatic carcinoma, and although we sometimes see an amelioration of the progress of the disease, there have been patients who have come to post. Just now we'd like to have Dr. Peters describe the changes that have been found in the pituitary and the neighboring areas in patients who have had a pituitary stalk section for metastatic carcinoma, and see exactly what is accomplished by this approach.

Dr. Peters (Pathology):

In discussing this problem, one has to know the anatomy of the pituitary and the hypothalamus.

There are at least three important areas in the hypothalamus which are related to the pituitary. I shall briefly mention two of them. The most important areas and the areas that have most extensively been studied are the supraoptic and the paraventricular nuclei. Short neuronal connections exist between these nuclei. The supraoptic nucleus, in particular, apparently produces some material which is necessary for posterior lobe function. This material is secreted in the neurons of the supraoptic nucleus then transported along the axon between the supraoptic nucleus and the posterior lobe of the pituitary. As a result of a transection of the stalk of the pituitary retrograde, changes in the supraoptic nucleus would be seen first. This has been demonstrated experimentally. Rasmussen and Garner reported that the normal neuronal population in a human brain of approximately 60,000 ganglion cells in the supraoptic nucleus was reduced to a mere 9,000 over a period of five and a half months after a stalk section. The changes in the paraventricular nuclei are less conspicuous; they are even debatable. On the average it has been estimated that there is a loss of approximately 20 per cent of the neurons in this nucleus in the experimental animal; the reason for this inconspicuous change in the neurons of the paraventricular nucleus probably is a matter of time, since the pathway between the two nuclei is not directly destroyed as in the supraoptic hypophyseal pathway.

In this one previous case which we have studied so far, we found (after pituitary stalk section had been performed 105 days before) a reduction of the cell number. Although we have not done cell counts, and these need to be done, and we have not as yet completed our survey of all the nuclear regions to be able to make more than an approximate estimate on a subjective basis, there is a marked reduction in the number of cells in the supraoptic nucleus, as compared to normal. The reduction in the paraventricular nucleus also did not impress us as being too conspicuous.

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Another important area which has not yet been studied extensively and perhaps needs further examination is the infundibular nucleus. It consists of a great number of very small neurons which apparently also have direct connections with the stalk of the pituitary and possibly with the anterior lobe. One peculiarity of this area is the absence of a subependymal glial layer. To my knowledge it is the only other area in the brain where this limiting glial membrane is absent. The other is between the anterior and posterior lobe of the pituitary.

As far as the anterior lobe of the pituitary following transection is concerned, we will, of course, find an infarct as is produced by a vascular occlusion or, as in this case, by severing the superior hypophyseal artery in the stalk. Here, most of the anterior lobe of the pituitary was destroyed, and there was only a small margin of cells left on the outer border of the pituitary. These cells primarily were chromophobes and basophils. This finding of survival of cells may be of importance when considering the results of the two techniques which are available, either radical removal of the pituitary or stalk section. Experimentally it has been shown that there is some regeneration of the anterior lobe of the pituitary if the stalk is cut. (We have recently seen another case of stalk section in which only very little anterior lobe tissue was destroyed).

The distribution and location of the different cells of the anterior pituitary is interesting. In the case under discussion, most of the eosinophils have disappeared. Normally there is a considerable variation of the percentage of the three different cell types among each other, but their location is almost always constant. The eosinophils are found primarily in the middle and anterior portion of the anterior lobe of the pituitary, the chromophobes and basophils more in the lateral and the anterior segments. The supraoptic nuclei and the paraventricular nuclei are about the best vascularized areas of the brain and, for that matter, in the whole human body. This may point to the importance which these two nuclear regions have with regard to endocrine function. The exact mechanism and importance of the portal system of veins in the pituitary has been long debated and no definite conclusion has been reached so far.

Dr. Owen:

To sum up what we have covered, we can say that there is experimental and some clinical basis for the use of this therapy in patients with diabetic retinopathy. We accomplish to a certain extent, perhaps to an almost complete extent, a therapeutic hypophysectomy by interrupting the stalk. We do

this not only because we infarct it, but because as far as ACTH, gonadotropins, and thyrotropic hormones are concerned, the secretion of these materials from the anterior pituitary appears to be dependent on hypothalamic stimulation. This stimulus is probably a humoral one which is carried via the hypophyseal portal system, without which it cannot reach the anterior pituitary and the pituitary cannot discharge these tropic hormones. Now, Dr. Smith has asked me two questions which I cannot answer, the first, "Why may there be a persistence of function of the follicle stimulating hormone?", and the second, "Why the changes in the diabetes insipidus?" Certainly, the follicle stimulating hormone being secreted by the basophils should be absent when the basophils no longer exist. Actually, I think some studies have shown that if there is any viable pituitary tissue left, it is that which receives a tiny amount of circulation from the dura, that is, the very rim or shell of the pituitary. These cells are predominantly gonadotropin-secreting basophils by many observers' estimate and, therefore, there may be just enough there to carry on a little gonadotropic function. The second point, with regard to the diabetes insipidus, I think may have some relationship to what Dr. Peters said about 9,000 neurons persisting after an original 60,000. Actually, the figure of 15 per cent (which this represents) is about the borderline—the percentage of surviving neurons must fall below 15 per cent before you get any symptoms of diabetes insipidus.

Dr. Smith:

Dr. Peters has a slide that might be of interest on the predominance of basophils retained which might correlate with your statement that these are the cells responsible for the follicle stimulating hormone.

Dr. Peskin (Resident in Medicine):

I was just wondering why the large amount of Pitressin® was necessary to control the temporary diabetes insipidus for a period of, say, several days. It has been our experience in four cases now, two for this particular situation and two because of malignancies where diabetes insipidus was much worse in diabetics and polyuria was due to diabetes per se. On the other hand, why would this patient require a larger amount of Pitressin®, say six to eight units within one 24 hour period, and show a type of resistance to Pitressin®?

Dr. Owen:

Well, the patients immediately following surgery are presumed to be completely lacking in antidiuretic hormone; although some is there, it's not being released, but is immobilized as a result of the trauma of surgery. The patients with spontaneous diabetes insipidus may be those who still maintain a

low supraoptic nucleus function and are still secreting a little antidiuretic hormone on their own, and you'd be just adding to that rather than, as in this case, supplying the whole amount by injection.

The first slide is a comparison of the laboratory values in a patient who had a hypophyseal stalk section which was done in the fall of 1957. It shows that there was no particular change in the calcium, but some fall in the phosphorus. This is of interest because this was a patient with acromegaly, and many people feel that the level of the serum phosphorus is indicative of the activity of the acromegaly. The electrolytes do not impress me as showing any significant change. The 17-ketosteroid and hydroxycorticoid secretion seems to be fairly normal before and after, but the postoperative values are affected by the Cortisone® substitution therapy. The protein-bound iodide fell promptly after surgery, indicating a loss of thyrotropic function, a loss of stimulation of the thyroid to release its hormone. The radioactive iodine uptake shows a fall also, which is not quite as marked; usually they both show a fairly equal fall. The last value is what is so interesting. Preoperatively the patient had ± 66 M. U. of follicle stimulating hormone and postoperatively it was still up in the neighborhood of 52 M. U. I could only repeat the arguments that I've advanced before as to why this activity might persist.

The next slide is a chart of the Carter-Robbins test in this same patient, showing that even after pituitary stalk section she had good antidiuretic response to an infusion of hypertonic saline, with a fall in urine output and a rise in specific gravity. The next slide is the chart on another patient with spontaneous diabetes insipidus, and here you see that the hypertonic saline produced only temporary slight decrease in urinary output without any change at all in the specific gravity, whereas the Pitressin® caused an immediate response in both these directions.

The next slide is a skull X-ray of a patient who had pituitary stalk section for metastatic malignancy. You can see in the pituitary fossa the metal clip which was put on the upper part of the stalk, and you can also see some radioopaque material here in the posterior fossa. This is lipiodol. An interesting thing is that 11 days previously (before operation), the patient had complete spinal canal block due to metastatic prostatic carcinoma, and within the period of time of nine to ten days postoperatively this had diminished enough to allow the myelogram material to travel up into the skull, which is an indication of how rapidly some of these malignancies may regress following hypophysectomy, functional or actual. The next slide is another chart on the same patient, showing that after operation there

was a rise in the serum alkaline phosphatase and a fall in acid phosphatase, and that there was an insignificant change in the urinary 17-ketosteroid and 17-hydroxycorticoid excretion, because these patients are maintained on Cortisone.® The long chart of the Pitressin® dosage shows that this patient continued to need Pitressin® tannate for at least two months postoperatively, then finally ceased to require it. Are there any question?

Dr. Waugh (Physiology):

Well, as far as that question was raised, why do these patients postoperatively seem to need a whole lot of Pitressin® to control the urine, but I think that might be tied up with how much steroid hormone these patients have, and how much steroid hormone these patients are given postoperatively. If one takes a normal person and gives him a large dose of Cortisone,® that will cause G. I. like symptoms, too, and I wonder if that might explain that thing in your experiments, and then you see titers of Cortisone® on the first several days.

Dr. Owen:

I think that's a very good point. Certainly the amount of solute that is going through the kidney tubules has a lot to do with the amount of urine flow, if that's all you're measuring, and if you give the patient big doses of Cortisone® this solute load will be high and therefore will necessitate a large amount of Pitressin® before the urine volume falls to what we call normal limits; later on, with a smaller dose of Cortisone,® this will even itself out. Dr. Smith, I'd like to ask you what your experiences with this operation for diabetic retinopathy have been at Hopkins, and what sort of patients you would like to see referred to you for consideration.

Dr. Smith:

The number of operatively treated cases in any group is small, and the three cases that were done, I believe, retained what visual acuity they had but I would say that there was no objective improvement in their retinal picture. I believe that the earlier we're to get these patients, the more likely we are to help them before the retinopathy has progressed too far, and certainly before there is serious nephropathy. I think if the nephropathy is too serious, this precludes pituitary surgery and we probably should avoid those patients, i.e., the very seriously ill patients with poor renal function and already advanced glomerular disease. We'll do well to avoid, rather than to encourage, surgery in this type of patient.

Dr. Owen:

I'd like to agree with that; certainly I don't think we want to operate on any more patients with advanced renal damage, as we have already done

Medical Grand Rounds

without any particularly favorable response. Also, I'm just wondering whether there would be any point in operating on patients who already have hemorrhages into the vitreous, because it seems to me that there's no way in the world that the hemorrhage can go away except by resorption and the process of resorption per se is apt to cause more damage by retinal detachment. I wish we had Dr. Fair here to crystallize our ideas about how much retinal damage is reversible and how much isn't, but there must be hundreds of patients who would still be candidates for the operation even using those very strict criteria.

Dr. Witham (Cardiology):

In respect to this last patient with Kimmelstiel-Wilson syndrome, would he be a very good candidate?

Dr. Owen:

I think not.

Dr. Withman:

He got no change in his endocrine requirements?

Dr. Owen:

The case today was not a case with any renal involvement, particularly. He had slight albuminuria, but good renal function. I was referring to a previous patient who had severe renal involvement, and, incidentally, he showed a marked insulin sensitivity post-op in that he used to take 30 units of lente daily and now he's gone ten days with no insulin at all, the blood sugars ranging from 46 to 121 mg. per cent.

Dr. Witham:

In the case presented today, there was no change in insulin requirement?

Dr. Owen:

Well, it's hard to say because we increased his diet and increased his insulin at the same time. He was discharged taking less than he had taken prior to admission, but whether that will be his permanent dosage or not, I don't know.

Dr. Smith:

The usual post stalk section insulin requirement is about one-third to one-fourth. This was also the reduction in Olivecrona's series. If a patient were taking 100 U., he would taper off and plateau at about 25 or 30 units daily. The blood pressure responses are very interesting. In their series there was a drop in blood pressure, which would be from, say, preoperatively 180/108. That pressure would drop down precipitously, possibly to 130 systolic and maybe 90 diastolic, but then there would be a gradual return to the normal pressure in 25 to 43 months.

Dr. Peters:

I think what Dr. Smith wanted to show was what I've already mentioned: There is only a small margin of about three or four cells thickness in the outer part of the pituitary that apparently has escaped the infarction.

Dr. Owen:

I think our time is about up, so are there any other questions?

Dr. Waugh:

Yes, there's one point I would like to make, as it has been brought out that the patient has diabetes and then for some reason he goes like Sheehan's disease, his diabetic state is much less than before. That same thing has been known to occur for years in patients who have diabetes, and then go on and develop Addison's disease, and I wonder how the simple process of taking out the adrenals would compare with the process of taking out the hypophysis for stalk section.

Dr. Owen:

Adrenalectomy for diabetes came into vogue about the same time as hypophysectomy. I don't think as many patients have had adrenalectomy as have had hypophysectomy, and I believe that the overall results have not been as good, although a few isolated cases have shown some improvement. Of course we achieve a functional adrenalectomy as far as the glucocorticoids are concerned by hypophysectomy, and in either case you have to substitute a daily dose of Cortisone.[®]

Medical College of Georgia

1959 Annual Session Medical Association of Georgia

**Bon Air Hotel
Augusta, Georgia**

**May 17-20
1959**

STANDARDIZATION OF INSURANCE CLAIM FORM

WITHIN THE NEXT FEW WEEKS each member of the Association will receive a supply of the new standard medical and surgical insurance claim form recently approved by the Medical Association of Georgia. To offset the volume of paper work by the physician in filling out the multitude of different insurance claim forms, this single form with simplified standard questions in a standard sequence is recommended for *commercial* types of accident and health insurance reports. *Commercial* types as referred to herein, are intended to include all types of accident and sickness insurance, with the following exceptions:

1. Industrial insurance (Weekly premium plans for which a special short form is being devised)
2. Compensation cases
3. Blue Shield Plans

Replacing a great variety of questions and forms from hundreds of insurance companies, the simplified standard claim form will embody these principal features:

(1) A basic attending physician's statement; one for *Group* accident and health insurance, and the other for *Individual* and family health policies. The standardized form carries the Group Insurance statement on one side of the form and the Individual Insurance statement on the other side of the form and only the appropriate statement need be filled out leaving the other side of the form blank.

(2) The questions in the statement are standardized in wording and in the order in which they appear, thus aiding in the ease of filling out the form and standardizing the physician's office carbon copy of claims filed.

(3) The questions are only those necessary to establish proof of loss in routine claims and are so worded and spaced as to cut down paper work.

(4) An assignment of benefits is included at the bottom of the form.

(5) The MAG adopted standardized claim form bears the identifying symbol of the Health Insurance Council signifying that the HIC has developed and approved this claim form. The HIC, an organization representing health insurance companies, has

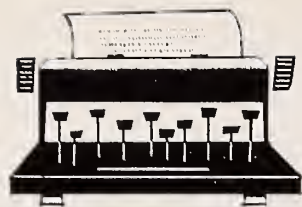
recommended usage of this form by all health insurance companies. Any form received from an insurance company bearing this HIC symbol is either a duplicate of the MAG standard form or an abbreviated version which may be used at the doctor's discretion.

It is the aim of your Association with the cooperation of the Health Insurance Council to initially supply each MAG member with this standardized claim form. The Association asks that physicians cooperate in using standard claim forms bearing the HIC symbol.



If an insurance company wishes a physician to fill out any form for commercial accident and health claims other than the MAG standard form or the exceptions referred to above, the MAG member should substitute the MAG standard form. The physician should send the company the completed MAG standard claim form, attaching the company's form left blank, with a notation that if the company wishes their claim form filled out, or any additional data—the physician will do so at a reasonable charge. By this procedure it is believed that in time all insurance companies will adopt HIC standard claim forms.

The Association's committee on Standardization of Insurance Forms and the Insurance Board, along with the HIC, have worked on this problem for many years and it is believed that the standardized forms will be of great advantage to all physicians. Georgia physicians are urged to use this form and instruct their office assistants to follow this recommended procedure.



editorials

New Simplified Claim Form

IN THE UNITED STATES today in excess of 70 per cent of the population is covered by some form of health insurance. This protection is written by more than 1,000 different insurance companies. Small wonder that the practicing physician has had an increasing problem handling the various claim forms which, on occasion, seem unnecessarily complicated.

Six years ago the Insurance and Economics Committee of the Medical Association of Georgia began working on this problem with the Health Insurance Council which is a national association of companies writing health insurance. It was learned with encouragement that the insurance companies were as aware of the existing problem as were the doctors. From this point the Health Insurance Council began working on a simplified and standardized claim form which would be acceptable to all companies writing this kind of coverage. However, this type of problem takes time with the meetings and many points of departure before a final compromise is reached. Yet, this compromise has been reached and the Health Insurance Council prepared what is now known as a *simplified claim form*.

Last year a committee headed by Dr. Joseph B. Mercer of Brunswick, Georgia gathered all the necessary information and spear-headed the adoption of this simplified claim form by the Council of the Medical Association of Georgia and the Health Insurance Council. This form will now be the

standard for the state of Georgia. The clerical load on the doctors of Georgia will be materially reduced by having only one type of form to complete for commercial health insurance claims.

The Blue Shield plans in Georgia have for some time had a shortened claim form which has been widely accepted by the medical profession. This form will continue to be used by these plans. Other exceptions to the MAG standard form are those forms for compensation cases and the forms for the weekly premium plans which will soon be standardized by MAG on a postcard size report.

The cooperation of the insurance industry in helping the medical profession lighten its clerical burden has been gratifying. As the use of this form is adopted it is expected that there will be some delays. The Insurance Committee feels certain that the doctors of Georgia will use their usual good discretion at the outset in transferring from our present dilemma of multiple forms into the use of the standard form. It is hoped that within a few months all insurance companies doing business in Georgia will have accepted this simplified form. This acceptance will result in a real relief to the physicians.

If any doctor over the state has any questions concerning this claim form change, it is requested that he communicate with the Executive Office of the Medical Association of Georgia.

The Carcinoid Story

THE RECENT VISIT of Dr. Albert Sjoerdsma to Atlanta has prompted this editorial. His interest in the carcinoid syndrome is why most Americans are interested in the subject today.

William Harvey wrote:

"Nature is nowhere accustomed more openly to display her secret mysteries than in cases where she shows traces of her workings apart from the beaten path; nor is there any better way to advance the proper practice of medicine than to give our minds to the discovery of the unusual law of nature by careful investigation of the cases of rarer forms of disease."

The carcinoid story (argentaffinoma) is such a story. The clinical features of the malignant carcinoid syndrome are so fascinating that it is impossible to forget them. The malignant carcinoid usually develops from a small primary lesion of the ileum. The neoplasm metastasizes to the liver, ovaries, lungs, and to bone. The clinical picture is largely due to the secretion of serotonin (5-hydroxytryptamine) by the tumor and to the disturbance of the metabolism of tryptophane.

The patient may exhibit paroxysmal erythematous flushing of the face and neck, telangiectasis, hyperperistalsis, diarrhea, nausea, vomiting, bronchial asthma, weight loss, skin lesions of pellagra, pulmonary and tricuspid valve lesions, right heart failure, hepatomegaly, fever, leukocytosis, peptic ulcer, and scleroderma. The simple urine test for 5-hydroxyindolacetic acid confirms the diagnosis. The ingestion of bananas gives a false positive test and chlorpromazine may cause a false negative test. Patients on Robitussin® and Tolserol® produce urine that turns red or pink when tested for 5-HIAA. These colors are not a positive test color—only purple is acceptable. The tumors grow slowly, therefore radical surgery is indicated, including metastatic lesions when possible.

The disease has stimulated a new interest in serotonin, and the patients with the disease have contributed greatly to the study of the metabolism of this substance. Because of their misfortune we now know more about serotonin and related substances than we would have known.

A vasoconstrictor substance, later identified as serotonin, was identified in clotted blood back in 1884. Four years later the carcinoid tumor was described. This tumor and the humoral substance

were not associated for over 70 years. In 1925 it was found that the vasoconstrictor substance is inactivated by perfused lung. Twenty-five years later the inactivator, an enzyme called monoamine oxidase (MAO), was identified. The vasoconstrictor material was isolated and crystalized in 1948 and was called serotonin (or enteramine by another investigator). The structure of this material was defined by synthesizing it in 1951. In 1955 the metabolic degradation of serotonin to 5-hydroxyindolacetic acid (5-HIAA) was demonstrated; increased urinary excretion of this 5-HIAA by patients with the carcinoid syndrome was demonstrated and the simple diagnostic test for the urinary 5-HIAA was developed by Sjoerdsma.

Using radioactive carbon labeled tryptophane in patients with the carcinoid syndrome, the entire metabolic cycle of serotonin was defined (Figure 1).

Normally, only a very small fraction of the ingested tryptophane will go to serotonin. In the presence of an argentaffinoma, however, large amounts of tryptophane are channeled in the production of serotonin and, as a result of tryptophane deficiency, pellagra may develop in these patients.

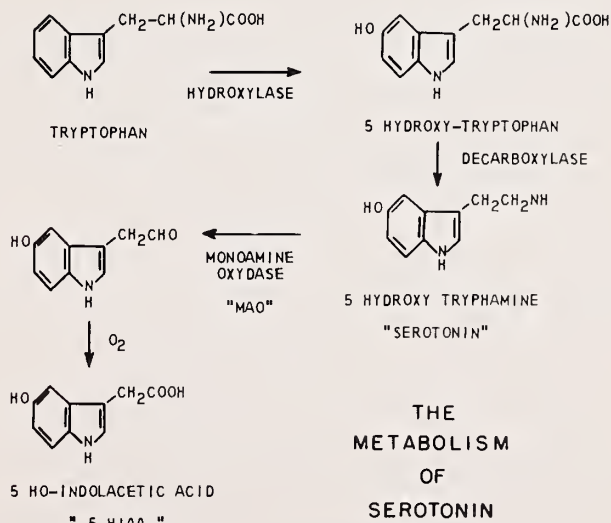


Figure 1: The Metabolism of Serotonin.

The distribution of serotonin is widespread in the body. Large amounts were found in the brain, platelets, gastrointestinal tract, and the spleen. Small amounts were found in the liver and bone marrow. Minute amounts were found in the lungs, thyroid, and pancreas, and none was detected in the skeletal muscles, peripheral nerve, and adrenal gland. The distri-

bution of serotonin in the brain is similar to that of norepinephrine and, interestingly enough, that of monoamine oxidase (MAO). Highest concentration was found in areas associated with the autonomic nervous system, the brain stem, and rhinencephalon. Serotonin in the brain cell is present in a precursor state, bound to cell structures protecting it from destruction by MAO. In the blood, the platelets are the carriers for serotonin. Only minute amounts of serotonin are present in the plasma.

The precise role of serotonin in blood coagulation is not clear. In human beings it appears that an intravascular clot, by releasing serotonin, stimulates fibrinolytic activity within the vessel itself. Serotonin probably protects small vessel integrity. Reserpine® causes marked and prolonged depletion of platelet serotonin in man without influencing hemostasis or without affecting platelet morphology.

Serotonin has both a pressor and depressor effect on the arteries. The pressor effect is probably local and the depressor effect is dependent on the existing neurogenic tone. It produces capillary dilation, increases capillary permeability, and increases small and large vein tone. Similar to epinephrine and norepinephrine, it produces coronary artery dilation and increases cardiac output. It is a powerful stimulant of the carotid body chemoreceptors. Serotonin increases pulmonary artery pressure and, probably through this mechanism, is involved in the vascular effects of pulmonary embolism.

Whether serotonin is a true "renal hormone" is not clear. In the human it reduces renal blood flow and glomerular filtration rate; it produces sodium retention and may increase potassium excretion. Serotonin, in the animal, can produce renal cortical necrosis similar to that found in women who die more than 24 hours after severe abruptio placentae. Since massive blood coagulation is associated with abruptio placentae, the disruption of platelets would liberate large amounts of serotonin.

Brodie thought that serotonin plays a role in central neuro-transmission in a manner that acetylcholine plays in peripheral synaptic transmission. It can be liberated in a free form transiently and can be rapidly inactivated by monoamine oxidase (MAO). The concentration of MAO in tissues is inversely proportional to their cholinesterase content. It is quite likely that the physiologic role in nerve transmission of MAO is analogous to that of cholinesterase.

Because serotonin is present in the same areas of brain where MAO is present, so serotonin must be bound and protected from this enzyme. Reserpine®, in vivo, interferes with the protective mechanism and

serotonin becomes available for oxidation by MAO. There is a prompt and transient increase in the urinary excretion of 5-HIAA following the administration of Reserpine.® The brain content of serotonin and, interestingly enough, also of norepinephrine, will decline following the administration of Reserpine.® Since Reserpine® does not interfere with the synthesis of serotonin, but probably disrupts its intracellular protective mechanism, it assures a continued low concentration which is responsible for the pharmacologic action of Reserpine® and other Rauwolfia alkaloids with a sedative effect. Other drugs with a similar action, like chlorpromazine and phenobarbital, are not associated with a decline of serotonin brain concentration. It is noteworthy that chlorpromazine antagonizes serotonin in a manner different from that of Reserpine.® Serotonin in a high concentration is a central nervous system stimulant. Monoamine oxidase (MAO) inhibitors, like iproniazid, will antagonize the sedative effect of Reserpine.® Anticonvulsants cause a rise in brain serotonin content.

The physiologic role of serotonin in mental function and in central neural transmission is being actively investigated at the present time. The role of serotonin in mental diseases may be quite important. LSD, which can produce transient symptoms of schizophrenia, is a potent serotonin antagonist.

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Citizenship in Fulton

THE CITIZENSHIP COMMITTEE and especially the participating doctors of the Fulton County Medical Society are to be congratulated on their enviable record of activity. Not satisfied with their remarkable record of participation in community projects in 1958 during which 360 doctors or 43 per cent of the Society membership took part in 1431 citizenship activities, the Committee has launched on an even more ambitious program for 1959.

In their program, the doctors are not only encouraged to go out and find extra-professional activities but to participate in various public medical information services which are planned for the near future. Medical symposiums have been proposed for the public at the Academy of Medicine on vital subjects on the first Friday evening of each month throughout the school year. A series of radio and television forums is currently in progress and more such programs are planned. A medical and health museum has been proposed to be set up at the Academy of Medicine under expert supervision, open every Saturday morning 9 to 12 A.M. throughout the school year. A list of vital medical and health subjects ready for presentation is to be printed in bulletin form and distributed widely to program chairmen of civic clubs. It has been proposed that

the individual physician's offices, hospitals, free clinics, pharmacies, etc. serve as information centers for the society's comprehensive information program.

Accredited press representatives are welcomed to Society functions and free access is maintained for the release of timely scientific material properly adapted for lay presentation.

Each year in recognition of outstanding contributions in the area of citizenship a member of the Society is nominated for the Aven Citizenship Award (endowed by a public-spirited, greatly respected, and beloved past president of the Society, Dr. C. C. Aven, and his wife). The judges for this coveted award are the presidents of the Atlanta Chamber of Commerce, the Atlanta League of Women Voters, and the Fulton County Medical Society.

The activities of the members of this Society through its outstanding Citizenship Committee have attracted national attention for the fine job they are doing. They have only begun to scratch the surface of public opinion, but in their efforts they are charting a pattern of public service and public relations which all county societies would do well to follow.

AMA OBTAINS LOWER FEES FOR AGED

THE POLICY MAKING body of the American Medical Association, the House of Delegates, is to be commended for its realistic action in urging lower fees by doctors for persons over 65 years of age with low incomes and resources in order that the latter may obtain low-cost voluntary health insurance.

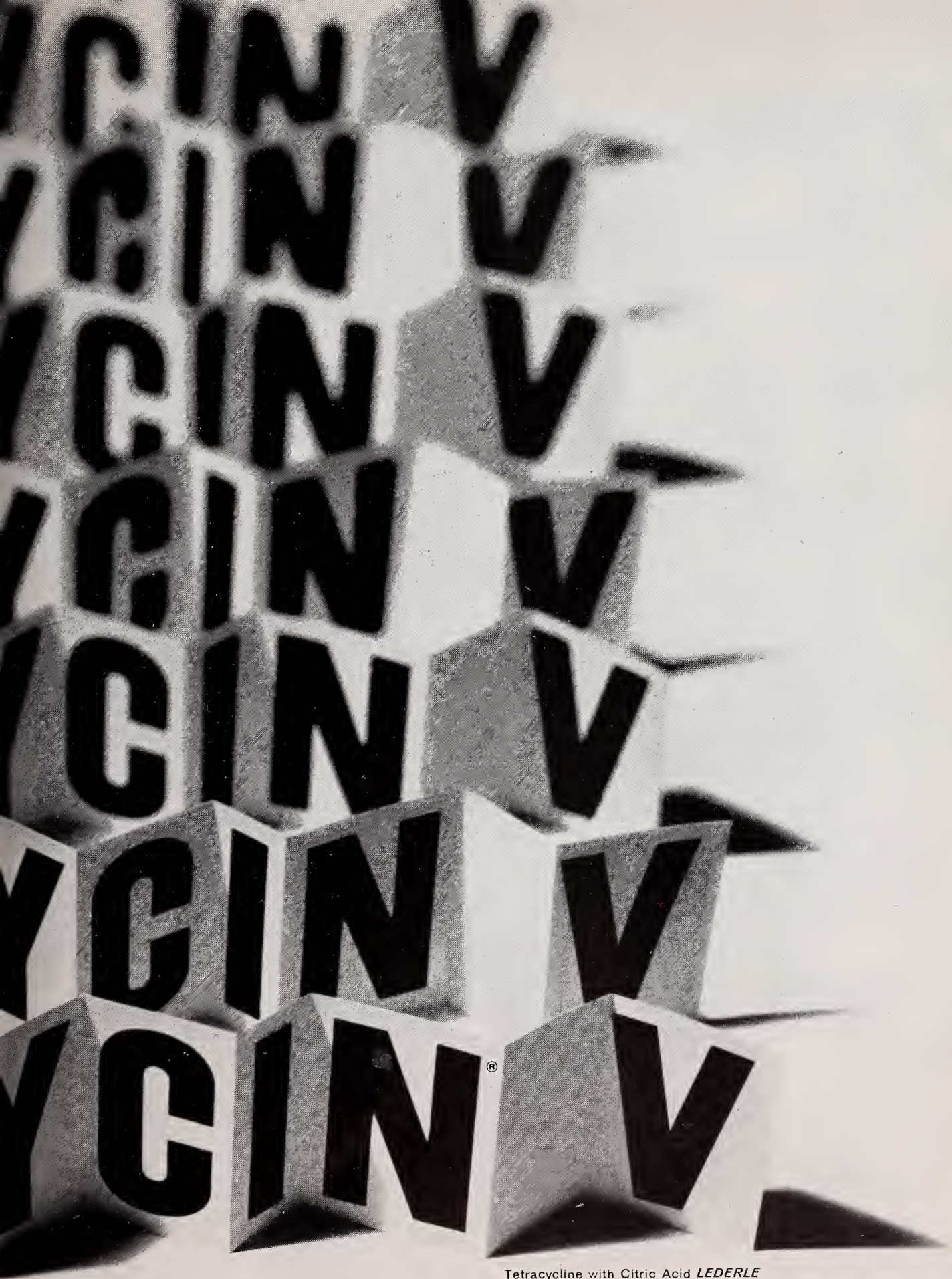
If physicians follow the recommendation of the House of Delegates, the way will have been cleared for developing a financially secure insurance system that will afford adequate coverage for the aged without lifting premium rates to unreasonable levels.

As it stands now, relatively few health insurance benefits accrue to the segment most in need of protection—the elderly.


Health Information Foundation data discloses that in a recent year more than 60 per cent of the nation's population was covered by some form of medical insurance, but that only 30 per cent of those persons over 65 years of age had such protection.

—Macon Telegraph





Tetracycline with Citric Acid **LEDERLE**



current clinical concepts

Macroglobulin Studies

MACROGLOBULIN STUDIES are reputed to be able to distinguish between disseminated lupus and rheumatoid arthritis. They showed in one series that one patient in five with the clinical picture of rheumatoid arthritis actually had lupus.

Personal communication: A. J. Merrill, M.D.

Hepatitis Without Icterus

HEPATITIS without icterus may lead to post hepatic cirrhosis.

Personal communication: A. J. Merrill, M.D.

ST-T Wave Changes

AN APPARENTLY normal heart suspended between the vascular pedicle above and the inferior vena cava below may show abnormal ST-T wave changes suggesting infarction of the lateral and postero-inferior portions of the left ventricle or may show left ventricular strain pattern (in children as well as adults).

Personal communication: A. J. Merrill, M.D.

Idiopathic Hemochromatosis

"THE DIAGNOSIS of idiopathic hemochromatosis should be borne in mind by any physician confronted with a middle-aged male patient suffering from cardiac failure of obscure cause, particularly if the diagnostic features somewhat resemble those of pericardial infarction."

Smart: Metabolic Disturbances in Clinical Medicine, Little, Brown and Company, 1958, page 150.

Lupus Nephritis

"LUPUS NEPHRITIS is a progressive fatal glomerulonephritis, which, at present, is the main cause of death and a most serious problem in patients ill with SLE . . . The majority of patients ill with SLE die of renal failure, and lupus nephritis is found on post mortem examination in over 75 per cent."

Hypertension in the Young

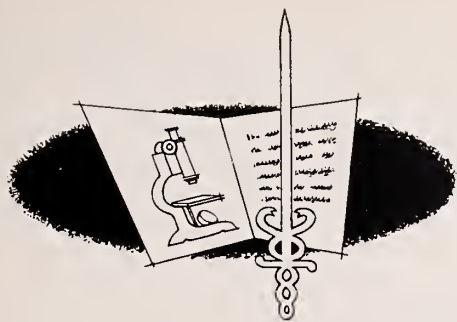
PRIMARY HYPERTENSION discovered in patients prior to age 25 may not progress more rapidly than in those in whom the disease begins at a later age. On a study of thirty patients, their mean survival time was 20 years. This represented the same life expectancy seen in patients previously studied whose average age at onset was 32 years.

Ann. Int. Med. Vol. 49, No. 6, P. 1348

Unexplained Diarrhea

MALIGNANT CARCINOID should be suspected in all patients with unexplained diarrhea and visible flushing. The primary tumor usually cannot be visualized by intestinal roentgenography. The diagnosis is established easily by a simple qualitative test of the urine. In this way some patients will be recognized to have this disorder at a stage when surgical intervention will result not only in palliation but also cure.

Archiv. Int. Med. Vol. 102, No. 6, P. 936



cancer page

THE LEUKEMIAS

Harrison Reeves, M.D., *Atlanta*

THE MOST IMPORTANT single problem in hematology is that of leukemia. In the United States it kills at least 10,000 annually. Statistics indicate the disease is on the increase. (United States Public Health Service reports document a three-fold increase in the incidence between 1930 and 1952).

Acute leukemia has been seen in children and is now a disease of paramount importance in adults, also. Chronic leukemia is seen almost entirely in adults. The various types of leukemia are named for the cell that is proliferating. Lymphoblasts are much more common than myeloblasts in the acute disease in children. In adults, chronic lymphocytic and myelocytic diseases are of approximate equal incidence.

"Aleukemic" leukemia presents in 30 to 50 per cent of cases of the acute process. This is sometimes extreme, with a leukopenia in the order of 300 to 500 w.b.c per cu. mm. Often in these instances of extreme leukopenia the morphologic diagnosis cannot be made until the bone marrow is studied. Marrow destruction by neoplastic over-growths can be surmized clinically in the face of pallor (anemia), purpura (thrombocytopenia), and sepsis (granulocytopenia).

There has been an enormous resurgence of interest in the disease, due largely to the possibility of achieving at least temporary results with various chemical agents. Laboratory animals offer exciting opportunities for basic research and the newer techniques for study bring the day of future solution of the problem closer at hand. Mounting clinical and laboratory observation leads one to suspect that

both viruses and ionizing radiation can serve to "trigger" the metabolic abnormalities that characterize leukemia. Many other various chemical and physical agents may do likewise.

One important manifestation of acute leukemia, not yet generally appreciated, is the occurrence of neurologic disease due to intracranial spread of neoplasia. This may occur either at the outset of acute leukemia in infants or later in the course of the disease in older children, frequently after months of chemotherapy. These patients may present as acute bacterial meningitis. Headache, irritability, vomiting, papilledema, and separation of the cranial sutures may be noted. The cerebral spinal fluid may be cloudy, with low sugar and elevated protein. Especially in the presence of petechiae the clinical picture may resemble meningococemia.

Pathologic changes in the nervous system at autopsy include: (1) Cerebral hemorrhage, (2) infiltration of meninges and central nervous system with leukemic cells, (3) perivascular cuffing, and (4) epidural infiltration of the spinal canal with invasion of the spinal nerve roots. Both X-ray and intrathecal methotrexate are effective modes of treatment. (note: Oral methotrexate does not cross the blood brain barrier in effective concentration).

As noted above, the temporary results with chemotherapy are encouraging and lend hope to a more prolonged, eventually permanent, control. The

Approved by Professional Education Committee, Georgia Division, ACS

folic acid antagonists, purine antagonists, and steroids in acute leukemias can be used with relative ease and safety when properly employed. There are many chemical agents now available, plus the time honored X-ray, for the control of chronic leukemia. The clinically useful alkylating agents

now include nitrogen mustard, triethylene melamine, Leukeran,[®] and Myleran.[®] Plasma cell leukemia (multiple myeloma) still responds best to Urethane.[®]

Finally, a word should be added regarding bone marrow homografting—the newest effort in the treatment of leukemia (and aplastic diseases). An excellent review is available in the November, 1958 issue of the *Annals of Internal Medicine*.

MEDICAL SCHOOLS HAVE RECORD ENROLLMENT

AMERICAN MEDICAL COLLEGES had a record enrollment of 29,473 students in 1957-58.

Sixty of the 85 operating medical schools reported major construction, costing 47 million dollars, in the planning, beginning, or completion stages.

Forty-nine schools reported major developments and changes in administrative organization, methods of student selection, curriculum, and financing.

An estimated 275 million dollars was spent by the medical schools in 1957-59, an increase of 13 per cent over the preceding year.

These were among the many facts and figures in the 58th annual report on medical education by the American Medical Association's Council on Medical Education and Hospitals.

The report illustrates some of the changes and developments being made in medical schools to meet the changing medical needs of the American people.

It also noted the A.M.A.'s continuing support in developing additional facilities for basic medical education. "The increasing population together with various other facets of the shifting [population] pattern obviously indicate the need for constantly increasing the number of physicians," the report said.

This means that existing medical schools must consider expanding their facilities, and institutions of higher education without medical education programs need to give serious consideration to the development of medical programs.

Major developments in curriculum and teaching methods were reported at several schools. These include a plan at Duke University to produce physicians who are also skilled medical research

scientists; a greater emphasis on education methods for medical teachers at the University of Buffalo, and an experimental program at the University of Pittsburgh whereby medical students may adapt their medical education to one of the specific fields of research, clinical specialties, or general practice.

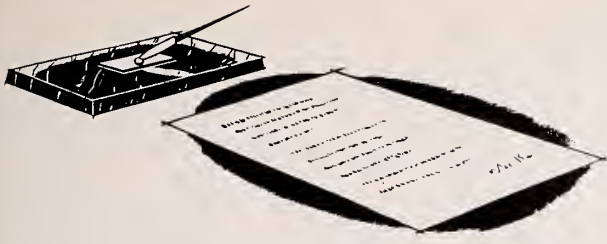
There are 78 approved four-year medical schools in the United States, along with four two-year schools of basic medical sciences. In addition, three newly developed schools have provisional approval by the A.M.A. council and will be graduating students within the next few years. Ten years ago there were 77 schools, including seven two-year schools of basic medical sciences.

A total of 6,861 physicians was graduated from the 78 schools in 1958, as compared with 6,796 in 1957. The record year for graduates was 1955 with 6,977.

A new record was established in 1957-58 for the number of entering freshmen—8,030. The preceding year the number was 8,014 and 10 years ago the number was 6,487.

A total of 1,644 women were enrolled in medical school, and 355 were graduated in 1958. Women's Medical College, Philadelphia, enrolls only women, while Dartmouth and Jefferson enroll only men.

Of the 72 schools reporting that the supply of cadavers used for teaching anatomy was probably adequate for the needs of first-year students, 13 reported an insufficient supply for the more advanced students. The other 13 schools reported a "frankly inadequate supply." The report urged more states to give legal recognition to individual bequests of bodies to medical schools.



abstracts by georgia authors

Allen, Lanier, B.S. and William R. Murphy, M.D., University Hospital, Augusta, Georgia, "Listeriosis," South M. J. 51:1454-1456 (Nov) 1958.

Two cases of meningitis due to *Listeria monocytogenes* have been seen at the University Hospital within one year. Both cases terminated fatally. The most important single factor in the recognition of this disease is an awareness of its etiologic agent. The organism is a somewhat pleomorphic, non-spore forming, gram positive rod, exhibiting an end over end type motility when at room temperature. *Listeria* is easily cultured on ordinary laboratory media. Organisms cultured were sensitive to Chloromycetin,® Furadantin,® Achromycin,® Neomycin® as well as the common sulfonamide drugs. They were not sensitive to penicillin by the usual disc method of testing. Listeriosis should be suspected in any case of meningitis in which a small gram positive rod is seen on direct smear of the centrifugal spinal fluid.

Smith, George W. and Marcelina Chavez, Medical College of Georgia, Augusta, Georgia, "Lumbar Extradural Cysts-Congenital," Arch. Neurol. & Psych. 80:436-440 (Oct) 1958.

Because congenital spinal cysts located extradurally in the lumbar spine present a definite clinical syndrome, they should be separated and identified by the diagnostic term, *congenital lumbar extradural cyst*. This rare cause of cauda equina compression is usually seen in adults with the duration of symptoms being measured in years. Back pain is a predominant symptom with loss of normal lordosis. Paresthesias are noted in one extremity and the patient will have hip and leg pain. The symptom complex is slowly progressive with lower motor neurone weakness developing in one leg. The reflexes are diminished to absent in this extremity. The characteristic X-ray findings are those of widening of the interpedicular space and thinning of the pedicle and lamina opposite the cyst with cavitation of the posterior border of the body of the vertebra. Myelography reveals a smooth outlined filling defect. Such a compressive cyst results from a congenital defect in the dura mater. A typical case history with the myelographic defect and artist's drawing of the operative findings is shown. The similarity of the syndrome with that

of a completely protruded lumbar disc is emphasized.

The case reported is the first in which the extradural cyst was visualized by a contrast substance placed within the cyst and the spinal canal intact. A review of the literature shows a high consistency of symptoms and signs with cysts located in the lumbar area. The dissimilarity of the findings in the case of a cyst located in areas other than the lumbar region, points clearly for the need of the diagnostic term *congenital lumbar extradural cysts* to be retained for these lesions and will prevent confusion of the symptomatology with the spinal extradural cysts.

Martin, J. D., Jr., and Jennings M. Grismore, Emory Hospital, Emory University, Georgia, "Leiomyosarcoma of the Esophagus," Surg. Gynec. & Obst. 107:238-242 (Aug) 1958.

1. Leiomyosarcoma of the esophagus is a relatively rare lesion; however, leiomyoma of the gastrointestinal tract occurs fairly frequently.

2. There have been 20 cases of leiomyosarcoma of the esophagus reported, and an additional case has been added to these.

3. As a rule, the symptoms are directly related to the size and location of the tumor and, for the most part, are primarily accompanied by obstruction.

4. The diagnosis should be suspected in a patient who has dysphagia of any duration. An esophagoscopy and a barium swallow are necessary to confirm the presence of this condition.

5. A biopsy of the suspected lesion may prove beneficial in making a diagnosis and permitting a clear decision as to the type and extent of the surgery.

6. In view of the relatively low grade malignancy of these lesions, if resected early, the results should be good. A simple resection will be sufficient if the tumor is a benign leiomyoma.

Fish, J. S.; R. A. Bartholomew; E. D. Colvin; W. H. Grimes, Jr.; W. M. Lester; and W. H. Galloway, 272 Boulevard, N.E., Atlanta 12, Georgia, "Premature Labor and the Ruptured Marginal Sinus," South M. J. 51:1464-1469 (Nov) 1958.

Study of the proximate causes of 258 cases of premature labor and late abortion reveals that rupture of the marginal sinus is associated in 21.9 per cent of cases. Temporal relations and placental

evidence indicate that the relation is causal. In frequency, this is exceeded only by premature rupture of the membranes, which accounts for 27.6 per cent of such labors. Though customarily assigned major roles in prematurity, placenta previa, abruptio placentae, and toxemia accounted for only 3.5 per cent, 2.6 per cent and 3.5 per cent, respectively, of 258 premature labors. Intrauterine fetal death due to cord accidents, erythroblastosis and diabetes preceded 11.2 per cent of premature labors and in 10.1 per cent of cases the cause was not determined. It is felt that the frequency of placenta previa as a cause of prematurity is significantly reduced by expectant management of hemorrhage.

Labor follows the initial hemorrhage in about 50 per cent of instances of rupture of the marginal sinus while approximately 50 per cent of sinus hemorrhages yield premature infants. The authors conclude that, though not heretofore included in the causes of prematurity, marginal sinus rupture is a major factor in this problem.

The article includes a review of diagnostic placental findings in sinus rupture and a discussion of the correlation of clot type and age.

Mason, W. Roy, Jr., and Elizabeth K. Adams, Emory University, Georgia, "Infectious Mononucleosis," Am. J. Med. Sciences 236:447-459 (Oct) 1958.

The diagnosis of infectious mononucleosis has been a controversial subject for more than 35 years. The differences of opinion have involved principally the significance and the interpretation of both the hematologic changes and the sheep cell agglutination or heterophile antibody test. Secondary, in most instances, to such variable opinions, a diversity of clinical manifestations has been described. These discrepancies are discussed and emphasis given to the concept that accuracy of diagnosis is a relative matter, dependent upon no single feature of the disease but upon the inter-relationship of various diagnostic factors, clinical and laboratory. Practical diagnostic criteria are suggested.

An analysis is made of 100 cases with respect to clinical data, diagnosis, treatment, duration of illness, and complications. The analysis indicates a reasonable consistency of clinical and labora-

ABSTRACTS / Continued

tory findings among these cases.

The divergent reports of investigators regarding alterations of the liver are discussed. Evidence is presented to suggest: (1) that alterations of liver function are quite common, and (2) that the usual hepatitis of infectious mononucleosis is probably different from that generally to be found in infectious and serum hepatitis.

Treatment is generally symptomatic and supportive, and prolonged bed rest is usually unnecessary. A small, selected group of 17 patients was treated with oral prednisone, which appeared to initiate prompt symptomatic improvement, especially the lessing of pharyngitis. The hormone did not obscure the valuable laboratory signs, but also it did not appear to shorten the total duration of illness. The ultimate value of steroid therapy in this disease remains to be proven.

It is the complications of infectious mononucleosis which, together with insufficient discrimination in the diagno-

sis, which have given the disease the reputation of being protean.

Crevasse, Lamar E., Bethesda, Md.; R. Bruce Logue, and J. Willis Hurst, Emory Hospital, Emory University, Georgia; "Syndrome of Carotid Artery Insufficiency," *Circulation* 18:924-934 (Nov) 1958; and Crevasse, Lamar E., and Bruce Logue, "Carotid Artery Murmurs, Continuous Murmurs Over Carotid Bulb—A New Sign of Carotid Artery Insufficiency," *J. A. M. A.*, Vol. 167 (Aug) 1958.

Carotid artery insufficiency is a common cause of transient cerebral ischemic attacks or of the "routine stroke." Carotid artery stenosis or occlusion has been demonstrated in approximately 10 per cent of routine autopsies. In an unselected series of 100 hospitalized patients of average age 52, localized systolic bruits were found over the carotid artery in seven and continuous murmurs in two. In a study of 100 older patients with an average age 75.7, eight per cent were found to have localized murmurs, seven being systolic in time and one being continuous. Five of the eight patients had neurologic symptoms. The authors found that a continuous

murmur, localized to the carotid bulb is a reliable sign of carotid occlusion. Other clues to this disorder are:

1. Palpably diminished pulsation of one carotid artery.

2. Transient attacks of monocular blindness with contralateral neurologic deficits.

3. Transient cerebral ischemic attacks related to postural hypotension, either spontaneous or induced by drugs such as chlorpromazine, meprobromate, Marsilid,[®] rauwolfia, barbiturates, etc.

4. The presence of a systolic or continuous bruit over the eyeball. The recognition of carotid occlusion demands care in the administration of the above drugs. Furthermore, the prompt treatment of cardiac arrhythmia, left ventricular failure, and hypotension accompanying myocardial infarction may prevent the occurrence of strokes. Long term anticoagulants therapy is of value in management. Endarterectomy and the institution of grafts gives promise of alleviating symptoms and preventing later complete thrombosis and irreversible neurologic defects.

NEW MEMBERS OF THE MAG

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Byars, Stevens	Spring Street Monroe	Active	Walton
Fitzpatrick, Paul E.	Talmadge Memorial Hosp. Augusta	DE 2	Richmond
Foster, Blake M.	Gibson Street Warrenton	Active	McDuffie
Humphries, Arthur L., Jr.	Talmadge Memorial Hosp. Augusta	DE 2	Richmond
Keeling, William M.	U. S. Army Hospital Ft. Gordon	Service	Richmond
McLendon, Harold L.	115 Ambulance Drive Carrollton	Active	Carroll-Douglas-Haralson
Parker, Prentiss E., Jr.	Cherokee Medical Bldg. Smyrna	Active	Cobb
Philpot, N. F., Jr.	1467 Harper Street Augusta	Active	Richmond
Proctor, Ernest E., Jr.	35 Jefferson Street Newnan	Active	Coweta
Scoggins, Henry D.	1108 Druid Park Ave. Augusta	Active	Richmond
Shearouse, John H.	Lavonia	Active	Franklin-Hart-Elbert
Walters, Gordon E.	Talmadge Memorial Hosp. Augusta	DE 2	Richmond
West, Jay H.	Talmadge Memorial Hosp. Augusta	DE 2	Richmond



heart page

THE FUTURE OF CARDIO-VASCULAR SURGERY

E. R. Jennings, M.D., *Brunswick*

IN TAKING STOCK of the forward strides in the surgical treatment of cardiovascular disease today, one is compelled to attempt to visualize the concepts of tomorrow.

Surgery of the Aorta and Its Branches

Except for trauma, present day surgery of the aorta and arteries is directed primarily toward the alleviation of two conditions: occlusive disease and aneurysms. Occlusive disease is treated by two basic methods; one is by opening the diseased vessel and removing the occluding tissue, and the other method is by means of graft. Recent studies have indicated that these techniques can be applied not only to peripheral arteries but to other branches of the aorta as well. Attention has been called to the partial or complete occlusion of the carotid arteries as a basis for approximately 20 per cent of all cerebrovascular accidents. By means of excision of the occluding plaque or by means of graft, some recovery from the cerebral impairment has resulted in many cases. In like manner, renal arteriography has demonstrated occlusive disease of the renal arteries as a cause for hypertension. Relief of the renal arterial lesion has resulted in return to normotensive states in many cases.

There have been many attempts to improve the circulation to the impaired myocardium. Operations ranging from ligation of the internal mammary arteries to attempts to excise the occluding material

and close the coronary artery primarily are in current vogue.

The surgery of aneurysms consists of either excision of the aneurysm and primary closure of the vessel or excision of the aneurysm and parent vessel with replacement by means of graft. Recent use of by-pass shunts and pump-oxygenators has allowed the surgeon to successfully remove aneurysms from any area of the aorta or its tributaries.

Looking at the inferences of the present day treatment of blood vessel lesions, one must postulate the possible advances of tomorrow. It does seem logical that future chemical debriding agents will be used for the actual chemical decomposition of arteriosclerotic degenerative products. It is also conceivable that radioactive isotopes could possibly be compounded to have an affinity for the obstructive lesions and thus be able to decompose arteriosclerotic plaques. It is conceivable that prophylactic use of one of these agents might be prescribed in the water supply.

It is also felt that suture techniques will give place to a type of chemical or enzyme technique which will be applied to the end of each structure resulting in a physiological "welding."

Surgery of the Heart

Present day treatment of cardiac lesions is resulting in the efficient management of valvular defects, closure of abnormal openings, and even the

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

occasional correction of complicated anomalies. Stenotic valves are being opened and valves with insufficiency are being repaired by suturing the annulus and by the use of plastics. Septal defects are being closed with increasing frequency. Anomalous pulmonary venous drainages are being corrected. Some cases of truncus arteriosus are being separated into their pulmonary and systemic components and attempts at correction of transposition of the great vessels is in the process of clinical trial.

Cardiac surgery of tomorrow will certainly insist on transplantation of the heart as one of the first steps forward. Transplantations will probably be accomplished by the combined use of the pump-oxygenator and the reduction of tissue specificity such as is seen in agammaglobulinemia. A further step in the development of this concept will be in the per-

fection of a plastic heart or heart-lung. The possibility of such a device being powered with solar energy, atomic energy, or by the self-winding watch principle seems applicable. Many of our followers might have small emergency "hearts" installed at accessible vessels as they approach the older age groups.

It would seem probable that many of the future advances in this field will depend on some type of electrical or chemical artificial hibernation which would allow the heart to be stopped, removed, a new heart or artificial device installed, and the patient brought out of hibernation.

The present day position of this field of surgery has depended upon the prayerful cooperation of the layman, the scientist, the family doctor, and the specialist. On this economic, scientific, and spiritual cooperation lies the real future of cardio-vascular surgery.

HEALTH INSURANCE BENEFIT PAYMENTS INCREASE

BENEFIT PAYMENTS TO AMERICANS covered by health insurance through insurance company policies exceeded \$2 billion during the first nine months of 1958, the Health Insurance Institute has reported. This represents an increase of better than 10 per cent over the same period in 1957.

According to the latest Consumer Price Index of the U. S. Department of Labor, the cost of medical care in the country has risen by 4.5 per cent over last year.

Reports from the nation's insurance companies showed that, from January 1 through September 30, 1958, benefits paid under group health insurance policies covering the costs of hospital, surgical and medical care, and loss of income totaled \$1.5 billion, an increase of 11 per cent over the first nine months of 1957. Benefits through individual and family type policies, the Institute said, increased by nine per cent to \$506 million.

Of the five major types of health insurance—major medical expense, hospital expense, surgical expense, regular medical expense, and loss of income—major medical showed the greatest increase in benefits paid.

Benefits received by holders of major medical expense policies, which help defray the cost of serious catastrophic illness, increased by 89 per cent over the same period last year to total \$167 million. This sum, divided between the \$162 million paid

through group plans and the \$5 million paid to the holders of individual policies, already surpasses the \$130 million in benefits paid out during all of 1957. These figures, the Institute added, include policies written alone or to supplement the basic hospital, surgical and medical coverages.

Persons covered under hospital expense policies, which help pay for the costs of hospital care, received a total of \$794 million, with \$622 million received through group policies, and \$172 million under individual insurance policies.

Surgical expense insurance, which helps reimburse the insured for operations, accounted for \$297 million in benefit payments, with \$242 million going to those protected under group policies, and \$55 million paid to individual policyholders.

Payments by insurance companies to persons covered by regular medical expense policies, which help pay for medical care and treatment other than surgery, amounted to \$56 million by September 30, the Institute survey showed. Of this total, \$49 million was paid out under group plans, and \$7 million through individual policies.

In concluding its report of health insurance benefits paid by insurance companies, the Institute stated that the increase in such payments rejects the growing importance to the American people of health insurance as a means of helping finance medical care.



the association

ANNOUNCEMENTS

American Trudeau Society, 54th Annual Meeting, May 25-28, Palmer House, Chicago, Ill. Symposium on smoking and lung cancer and another on pulmonary emphysema. Held in conjunction with the NTA. In addition to the symposia, there will be panels and lectures and daily morning and afternoon sessions when scientific papers will be presented on recent clinical and laboratory research in tuberculosis and other respiratory diseases.

14th National Conference on Rural Health, sponsored by the AMA's Council on Rural Health, March 5-7, Broadview Hotel, Wichita, Kan. Highlighted at the conference will be mental health, aging, nutrition, dental health, costs of medical care, and health insurance—and their effect on rural residents.

New York University Post-Graduate School offers the following courses in 1959: SURGERY OF THE HAND, a full-time course, March 16-21, Beekman-Downtown Hospital under the direction of Dr. William T. Medl. Maximum class 20. ORTHOPEDIC ASPECTS OF THE TREATMENT OF RHEUMATIC DISORDERS, a part-time course on three successive Tuesdays, 9 A.M. to 5 P.M., March 17-31. Extensive clinical material from the wards and clinics of Bellevue and University hospitals is used. Course under direction of Dr. Robert L. Preston. Maximum class 20. REFRESHER COURSE IN ALLERGIC CONDITIONS, full time course, March 23-25. A comprehensive review of recent advances in the diagnosis and treatment of allergic diseases. Under direction of Dr. Abner M. Fuchs. SEMINAR IN INTERNAL MEDICINE, full time, April 6 through May 29. Registration may be for entire course or part time in the various sessions, such as Allergy, Arthritis, Cardiology, Clinical Electrocardiography, Endocrinology, Gastroenterology, Hematology, Renal Failure, and Hypertension. Write: Office of Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, N. Y. 16, N. Y.

Augusta Graduate Assembly, April 6 and 7, Bon Air Hotel, Augusta. Approved category 1 for 9 hours credit in cooperation with the AAGP. Registration fee \$10.00. For information write: Augusta Graduate Assembly, Box 3323, Augusta.

Third annual seminar of the Atlanta Society of Pathologists, April 11-12, Atlanta. Various workshops will be held on Saturday, April 11 and a seminar and panel dis-

cussion on Neuropathology will be given Sunday, April 12. For additional information write Dr. John T. Godwin, 265 Ivy Street, N.E., Atlanta 3, Georgia.

Tenth Annual Symposium on Recent Advances in the study of Venereal Diseases, April 27-28, Johns Hopkins University, Baltimore, Md. Open to all physicians and workers in allied fields. Sponsored jointly by the American Venereal Disease Association and the Public Health Service.

DEATHS

ROBERT LEE HAMMOND, 65, died suddenly at his home in Jackson December 8, 1958.

Born in Butts county, Dr. Hammond had practiced medicine in Jackson for 38 years.

He was a Royal Arch Mason and a member of the Jackson Methodist Church where he formerly served on the Board of Stewards.

Dr. Hammond was a graduate of the University of Georgia and Tulane University. He received his medical degree from the University of Georgia Medical School at Augusta and was a member of the Medical Association of Georgia.

One of Dr. Hammond's greatest areas of service was as medical director of the Butts County Health Department.

Survivors include two daughters, Mrs. Robert S. Balk, Augusta, and Miss Carolyn Hammond, Jackson; one sister, Mrs. Don S. Thompson, Fort Pierce, Florida; three brothers, Oris F. Hammond, T. W. Hammond, and A. F. Hammond, all of Jackson; and several nieces and nephews.

ROBERT NATHAN LITTLE, 56, of Summerville died accidentally December 1, 1958.

Dr. Little attended Oglethorpe University and the Medical College of the University of Georgia where he received his medical degree. He was a member of the Pi Kappa Phi social fraternity and Phi Rho Sigma, national medical fraternity. He was a member of the American Medical Association and the Medical Association of Georgia. At the time of his death he was serving one of his many terms as president of the Chattooga County Medical Society.

Beginning the practice of medicine at Lyerly, Dr.

the association CONTINUED

Little moved to Chattooga County in 1929. In 1948 he established the Little Medical Clinic.

Survivors include his wife; two sons, R. N. Little, Jr. stationed with the U. S. Army in Germany and Gordon Little of Summerville; five sisters, Mrs. W. M. Faust of Crawford, Mrs. C. C. Pease of Cornelia, Mrs. Nan Lankford, Mrs. Dwight Henderson, and Mrs. H. A. Goodwin of Summerville; three brothers, T. B. Little and Frank Little of Cornelia and Dr. G. H. Little of Trion.

JULIAN F. CHISHOLM, SR., 82, of Savannah died December 13, 1958 after a long illness.

A native of Savannah, Dr. Chisholm had been in the medical profession there for more than 50 years before his retirement in 1955. He earned his medical degree at the University of Maryland Medical School, took post graduate work at Johns Hopkins, and served his internship in the Presbyterian Eye, Ear, Nose, and Throat Hospital in Baltimore, Maryland.

During World War I Dr. Chisholm served in the medical section of the U. S. Army. Having been an ardent sportsman, he was a charter member of the Forest City Gun Club.

He was a Fellow of the American College of Surgeons, a member of the American Medical Association, the Southeastern Surgical Congress, Medical Association of Georgia, Georgia Medical Society, past president of the Georgia Ophthalmological Club, Seaboard Air Line Railway Surgeons' Association, and for more than 40 years was ophthalmologist for the Seaboard and Central of Georgia Railways.

Dr. Chisholm was a member of the Sons of the Revolution and Sons of the Confederacy. He was a member of the Independent Presbyterian Church of which he had been a deacon for a number of years.

Survivors include his wife, Mrs. Nannie Levering Chisholm; two sons, Dr. Julian F. Chisholm, Jr. of Boston, Massachusetts and William W. Chisholm; two daughters, Mrs. Nancy Chisholm Daniel and Mrs. John C. Wylly; two sisters, Mrs. J. Ferris Cann and Mrs. Lawrence Maxwell; eight grandchildren; a great granddaughter and several nieces and nephews.

ALVIN J. WHELCHER died at the age of 80 in Cordele, December 15, 1958.

A native of Dawson County, Dr. Welchel had been a resident of Cordele for 54 years.

He was a member of the First Methodist Church where he served as chairman of the Board of Stewards and was active in other organizations of the church.

Dr. Welchel was a past president of the Crisp County Medical Society and a member of the Shrine and Elk's Lodge. He was active in the various civic organizations of Cordele and Crisp County.

Survivors include his wife; three sisters, Mrs. C. T. Bell, Grenada, Mississippi, Mrs. T. D. North, Macon, and Mrs. John H. Fenn, Cordele; six brothers, Henry C. Welchel, Cordele, Ben Welchel, Rochelle, Kelous Welchel, Birmingham, Alabama, Don Welchel, West

Helena, Arkansas, Homer Welchel, Chattanooga, Tennessee, and Lee Welchel, Macon; and a large number of neices and nephews.

SOCIETIES

A. L. Horton of Cartersville will head the **BARTOW COUNTY MEDICAL SOCIETY** as president for 1959. Thomas Hamilton was named secretary and treasurer, and W. B. Quillion was named vice president.

Sam E. Patton has been elected president of the **BIBB COUNTY MEDICAL SOCIETY**. Other officers include W. D. Hazelhurst, president; John T. Dupree, vice president; Calder Clay, Jr., re-elected as secretary; and Milford B. Hatcher, member of the executive committee.

Byron Steel, Fairmont, was elected president of the **GORDON COUNTY MEDICAL SOCIETY** at a recent meeting. Named to serve with Dr. Steele are R. D. Walter, vice-president and W. D. Hall, secretary.

Fred Schmidt of Marietta has been elected president of the **COBB COUNTY MEDICAL SOCIETY**. Serving with him will be Hugh Colquitt, vice-president and Remer Clark, secretary-treasurer.

The Gainesville Pilot Club, with the **HALL COUNTY MEDICAL SOCIETY**, have successfully completed a project of sponsoring a polio shot clinic in Hall County.

P. F. Brown, Jr. will serve as president of the Hall County Medical Society next year. Others elected were Oliver T. Ghent, vice-president; Hamil Murray, secretary-treasurer, and delegates to the state convention of the MAG are P. K. Dixon and Rafe Banks, Jr.

Katherine Hendry of Pierce has been elected president of the **WARE COUNTY MEDICAL SOCIETY** for 1959. Serving with her will be Vilda Shuman of Waycross as vice-president.

The **WALKER-CATOOSA-DADE MEDICAL SOCIETY** has elected N. H. Hutchinson president of the organization for 1959. President-elect for 1960 is Warren Terrell of Fort Oglethorpe. Secretary-treasurer is E. M. Townsend of Ringgold.

EMORY UNIVERSITY SCHOOL OF MEDICINE **Announces a Postgraduate Course in** **CONGENITAL HEART DISEASE** **March 26, 27, and 28, 1959** **at Grady Memorial Hospital**

FACULTY:

DR. S. GILBERT BLOUNT, JR., Associate Professor of Medicine, University of Colorado, Denver, Colorado
DR. RICHARD G. LESTER, Assistant Professor of Radiology, University of Minnesota, Minneapolis, Minn.
DR. JOHN W. KIRKLIN, Assistant Professor of Surgery, University of Minnesota Graduate School, Rochester, Minnesota.

FOR FURTHER INFORMATION WRITE:
Postgraduate Education
69 Butler Street, S.E.
Atlanta 3, Georgia

FEE — \$50.00

**MAG Council Meeting
December 13, 14, 1958**

CHAIRMAN GEORGE R. DILLINGER called the Council of the Medical Association of Georgia to order at 2:50 P.M., December 13, 1958 in the meeting room of Morrison's Restaurant, Valdosta, Georgia.

Council members present included: Lee Howard, Savannah, President; Luther Wolff, Columbus, President-Elect; George L. Alexander, Forsyth, 1st Vice-President; Charles W. Hock, Augusta, 2nd Vice-President; Chris J. McLoughlin, Atlanta, Secretary-Treasurer; Thomas W. Goodwin, Augusta, Speaker of the House; Charles T. Brown, Guyton, 1st District; George R. Dillinger, Thomasville, 2nd District; W. G. Elliott, Cuthbert, 3rd District; Virgil B. Williams, Griffin, 4th District; J. G. McDaniel, Atlanta, 5th District; Henry H. Tift, Macon, 6th District; D. Lloyd Wood, Dalton, 7th District; F. G. Eldridge, Valdosta, 8th District; C. R. Andrews, Canton, 8th District; and Addison Simpson, Washington, 10th District.

Vice-Councilors present included: T. A. Peterson, Savannah, 1st District; J. Z. McDaniel, Albany, 2nd District; David R. Thomas, Jr., Augusta, 10th District; also present was Joseph B. Mercer, Chairman, Committee on Standardization of Insurance Forms.

Mr. M. D. Krueger, Mr. John Kiser, and Mrs. Emily Grinalds of the Headquarters Office staff were also present.

Chairman Dillinger called on Thomas W. Goodwin who gave the invocation.

MINUTES

Mr. Krueger read the minutes of the September 13-14, 1958 meeting of MAG Council. These minutes were approved as amended, with the following correction: it was voted on motion (McDaniel-Peterson) that in the matter of the Georgia Plan information presented by W. G. Elliott, the wording be changed from "tabled" to "dropped." Mr. Krueger then read the minutes of the meeting of the Executive Committee of September 14, 1958; October 30, 1958; and November 23, 1958, and these minutes were approved as read.

A.M.E.F. REPORT

Mrs. Grinalds reported that 13 additional County Societies and individuals have sent contributions to the A.M.E.F., totaling \$938. The total amount received to date was \$1,758. On motion (McDaniel-Williams) it was voted to publish in the *Journal of the Medical Association of Georgia* all County Medical Societies who have contributed 100 per cent to the A.M.E.F., and to continue publishing these reports of 100 per cent contributions as they come in to the Headquarters Office.

1959 AUGUSTA ANNUAL SESSION REPORT

Chairman Dillinger called on Henry Tift, Chairman of the Annual Session Committee, who reported on the Scientific Program and Commercial exhibits for the 1959 MAG Augusta Annual Session. Dr. Tift reported that the Scientific Program was complete. He spoke of certain lectureship problems, and stated that a uniform system is needed to eliminate confusion. On motion (Thomas-Peterson) it was voted that a MAG Lectureship Committee of three members be appointed as a rotating permanent committee of Council, and that the Chairman serve in an Ex-Officio capacity on the Council Annual Session Committee.

INSURANCE COMMITTEE REPORT

David R. Thomas, Chairman of the MAG Insurance and Economics Committee, reported on a letter from Mr. Sheffield Owens, H.I.C. Georgia Representative. In this letter Mr. Owen explained the Health Insurance Council forms approved by the AMA. Dr. Thomas suggested that a supplement assignment be attached to the forms. General discussion ensued. At this point, Dr. Joseph Mercer stated that he withdrew his Committee's proposed insurance forms, and endorsed the H.I.C. "back to back" form. On motion (Tift-Elliott) it was voted: (1) that MAG adopt the H.I.C. "back to back" form with an assignment of benefits included as the standard insurance form endorsed by the Association; (2) that H.I.C. furnish MAG Headquarters Office a supply of these forms for distribution to MAG members; and (3) that the physicians be requested to use this form, and if an insurance company wishes additional information, a reasonable charge may be made.

**MONTHLY BUDGET REPORT AND PRESENTATION OF 1959 MAG
PROPOSED ANNUAL BUDGET**

Chairman Dillinger called on the Chairman of Council Committee on Finance, J. G. McDaniel, who reported on the December monthly budget. On motion (Peterson-Thomas) the Decem-

ber 1958 budget report was approved as read. Dr. McDaniel then presented the proposed 1959 annual budget. On motion (Thomas-Williams) it was voted to approve this budget with an increase for the Insurance and Economics Committee of \$200 totaling \$600. Dr. McDaniel and his committee were commended for their excellent efforts.

GEORGIA INSURANCE LAW REVISION

President-Elect Luther Wolff read proposed changes in the Blue Cross and Blue Shield enabling acts as prepared by the State Insurance Laws Revision Committee. The changes would broaden the concept of participating physicians. On motion (Williams-Alexander) it was voted by Council to approve the action of the MAG Legislative Committee on this matter, with authorization to continue to oppose the proposed changes and, further, that Council is unalterably opposed to any change in the present non-profit Hospital and Medical Service Acts.

The meeting was recessed at 5:45 P.M.

RECONVENED MEETING

The meeting of the Council of MAG reconvened at 8 A.M., Sunday, December 14, 1958.

COMMITTEE APPOINTMENTS

(1) *Practical Nurse Advisory Committee to Georgia Dept. of Education*—Enoch Calloway, LaGrange, was appointed to serve with Dr. Wood and Dr. Andrews.

(2) *Scholarship Committee of National Foundation*—It was voted to refer this matter to Executive Committee.

(3) *School Child Health Committee*—Grady Black, Griffin was appointed to replace Thomas McPherson.

(4) *Dept. of Health Hospital Advisory Committee for Licensure*—The term of MAG representative Milford Hatcher expires 12-11-58, and it was unanimously voted to re-appoint Milford Hatcher, Macon.

REPORT OF AMA CLINICAL MEETING DECEMBER 2-5, 1958

In the absence of C. H. Richardson, Macon, AMA Delegate, Chris J. McLoughlin read a report from Dr. Richardson for the information of Council as follows: The subjects considered at the meeting of the House of Delegates of the A.M.A. at the Minneapolis session consisted of Health Care of the Aged, report of the A.M.A. Committee on Medical Care Plans, osteopathy, expansion of medical education facilities, the Association's administrative changes, the report of the Committee to Study A.M.A. Objectives and Basic Programs, and voluntary health organization fund raising campaigns.

Dr. Lonnie A. Coffin of Farmington, Iowa was named the 1958 General Practitioner of the Year.

Dr. Gunnar Gundersen, A.M.A. President, called upon the medical profession to exert leadership in meeting the problems of these changing times. He stated that "The time has passed for policies based on generalities, platitudes, and flag-waving."

Governor Orville L. Freeman of Minnesota addressed the opening session, and asked for "the help of the leaders of the medical profession in working out a program that most adequately meets the needs of our older citizens for health care and services of the highest quality."

Registration showed that 2,870 physicians were present.

The most important subject discussed was Health Care of the Aged, and the following resolution was submitted and accepted by the Council on the Medical Service: "That the A.M.A., the constituent and component medical societies, as well as physicians everywhere expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources, and that physicians agree to accept a level of compensation for medical services rendered to this group, which will permit the development of such insurance and prepayment plan at a reduced premium rate."

The House directed that copies be distributed to medical society approved plans including Blue Shield and private insurance programs requesting their cooperation.

The long-awaited report of the Commission on Medical Care Plans, appointed at the 1954 Clinical Meeting in Miami, was discussed at length, but the House wanted to defer action until the June, 1959 meeting.

In the meantime they suggested that the medical societies and state organizations study two points: first: "Free choice of physician," and second: "Attitude toward closed panel systems."

Considerable discussion centered on a resolution which would have given constituent medical associations the right to establish the relationship of the medical profession to osteopathy within their respective states.

The House decided, however, that the question would evidently have to be solved on a national basis, and deferred action.

The House approved a statement by the Council on Medical Education and Hospitals supporting the development of additional facilities for basic medical education.

The House approved the Board of Trustees report on the administrative reorganization structure in the Headquarters Staff.

The House considered the various fund-raising problems which have arisen out of the concept of community effort, and went on record as saying that "The American Medical Association neither approves nor disapproves of the inclusion of voluntary health agencies in United Fund drives."

The House also took notice of recent restrictive changes in the Medicare program, and urged the Association to encourage its re-establishment under the free choice principle to accomplish the original intent of the act.

The House authorized the Council on Medical Services to sponsor a Congress on Prepaid Health Insurance.

It approved a By-Law amendment which will allow dues exemptions for interns and residents serving in training programs.

It heartily approved and lauded the purpose, content, and format of the *A.M.A. News*, and recommended continuance under the present established policy.

It called for continued activity at all levels to stimulate the development of effective poliomyelitis inoculations.

At the opening session six medical societies contributed a total of almost \$250,000 to the American Medical Education Foundation. The gifts were: California, \$150,305.75; Indiana, \$35,110; New Jersey, \$25,000; New York, \$19,608; Utah, \$9,977.50; Arizona, \$8,657.50. In addition, the American Medical Association announced a contribution of \$10,000 to the Foundation.

This should make us pause and think in Georgia!

FEDERAL MEDICAL SERVICES MEETING DECEMBER 1, 1958, MINNEAPOLIS

Secretary Chris J. McLoughlin stated that no specific recommendations were made at this meeting. The Council on Medical Services of the AMA had no recommendations to the House of Delegates. He reported that an attempt would be made to restore the full Medicare Program, provided they can have free choice of doctors.

MAG PRESIDENTS AND SECRETARIES CONFERENCE

Secretary Chris J. McLoughlin outlined the program for the proposed MAG President and Secretaries Conference to be held February 15, 1959. On motion (Tift-Peterson) it was unanimously voted to approve this conference.

FLORIDA COLLEGE OF MEDICINE LETTER

Secretary McLoughlin read a letter from Dean Harrell from the Florida College of Medicine concerning sending Georgia patients to the J. Hillis Miller Health Center, University of Florida, Gainesville. On motion (Goodwin-Simpson) it was voted that Dean Harrell be written that his revised letter meets with the approval of MAG Council.

HEADQUARTERS OFFICE REPORT

Mr. Krueger gave a report on the activities of the Headquarters Office Staff. On motion (McDaniel-Elliott) it was voted to approve the employment of Miss Anne Whiddon as Managing Editor of the *Journal of the Medical Association of Georgia*, to start January 19, 1959.

MEDICARE REPORT AND CONTRACT RENEGOTIATION

Mr. Krueger read a report written by Medicare Administrator, John Arndt. Discussion ensued. On motion (Wolff-Thomas) it was voted that Council go on record as opposed to any expansion of Medicare; that it be kept strictly within the October 1, 1958 restrictions, and that Council so notify Georgia representatives in Congress. On motion (Hock-Brown) it was voted that MAG Council commend Congress in its efforts to economize on this program. It was further voted that Chris J. McLoughlin draft a letter to Col. Lowry commending him for his activity in behalf of Medicare.

COUNCILOR APPORTIONMENT AND REDISTRICTING COMMITTEE REPORT

Thomas W. Goodwin, Chairman of Committee on Councilor Apportionment and Redistricting gave a report and showed slides with the proposed new districts. General discussion ensued. On motion (Wolff-McDaniel) it was voted that this matter be referred to a Special Reference Committee of the House of Delegates with the following suggested alternatives: (1) preserve the present representation on Council and the present districts; (2) preserve the present districts but allot one Councilor for each Society having members, and an additional Councilor for each additional 500 members in a Society. (Members of County

Societies having more than 100 members will not be eligible for voting on the Councilor and Vice-Councilor from the "district at large"); (3) approve the Constitution and By-Laws amendment first read at the 1958 House of Delegates meeting.

UNFINISHED BUSINESS

Chris J. McLoughlin, Chairman of Council Building Committee, reported that no recommendation could be made on the purchase of a suitable MAG Headquarters Building at this time.

CRAWFORD LONG MEMORIAL COMMITTEE

J. G. McDaniel, Chairman of Finance Committee, reported that \$1,500 was needed for the up-keep and care of the Crawford W. Long Memorial Bldg. On motion duly made and seconded it was voted to approve this appropriation.

CLARIFICATION OF MONEY USED BY COMMITTEES

Chris J. McLoughlin, Secretary-Treasurer, reported on some problems concerning clarification of money used by committees, and on motion (Eldridge-Hock) it was voted that MAG Committee members pay for their own meals except: (A) when committee meets to conduct business during the meal; (B) when the Headquarters Office has arranged the meal as a part of the meeting; (C) when it is necessary to host Association guests.

JOB SPECIFICATIONS

On motion it was voted (Goodwin-Elliott) to instruct the Executive Secretary to draw up minimum job specifications for Headquarters Office Personnel in consultation with Dr. Howard and Dr. McLoughlin.

COUNSEL FOR MAG

After general discussion, it was voted (Goodwin-Hock) that Mr. John Dunaway, MAG counsel, be replaced, and that Mr. Shackelford be retained as general counsel for MAG.

REVISION OF MEMBERSHIP BY-LAWS SECT. 10; JURISDICTION

On motion (McDaniel-Simpson) it was voted to refer this section of the Constitution and By-Laws to the Committee on Constitution and By-Laws for revision.

DATE AND SITE OF NEXT MEETING

On motion (Alexander-McDaniel) it was voted that the next meeting of Council of MAG would be held in March at the Cloister Hotel, and if this hotel is not available, the Executive Committee was empowered to find a suitable location in the Brunswick area.

Dr. Eldridge was given a rising vote of thanks for his hospitality to the Council of MAG.

There being no further business, the meeting was adjourned at 11:45 A.M.

Executive Committee of Council December 14, 1958

THE EXECUTIVE COMMITTEE of MAG Council was called to order by Chairman Dillinger at 12 Noon, Sunday, December 14, 1958, at Morrison's Restaurant, Valdosta.

Members of the Executive Committee present in addition to Chairman Dillinger were Lee Howard, Sr., Savannah, President; Luther Wolff, Columbus, President-Elect; Chris J. McLoughlin, Atlanta, Secretary-Treasurer; and J. G. McDaniel, Atlanta, Chairman of the Finance Committee.

Also present were Mr. Milton D. Krueger, Mr. John Kiser, and Mrs. Emily Grinalds of the Headquarters Office Staff.

LECTURESHIP COMMITTEE OF COUNCIL APPOINTMENTS

As recommended by Council, the following appointments were made to the Council Committee on Lectureships: (1) Mark S. Dougherty, Jr., Atlanta, three years; (2) George Alexander, Forsyth, one year; (3) J. W. Chambers, LaGrange, with George Alexander to serve as Chairman of this Committee.

DATE AND SITE OF EXECUTIVE COMMITTEE OF COUNCIL MEETING

It was voted that the next meeting of the MAG Executive Committee of Council be held in Atlanta on January 25 at 10:00 A.M. at the Headquarters Office.

There being no further business, the meeting was adjourned.

SCHOLARSHIP COMMITTEE OF NATIONAL FOUNDATION

On motion (McDaniel-Wolff) it was voted that Council write the National Foundation that our state has already made certain provisions for scholarships for deserving students, and that Council does not recognize a need at this time for participation in the Foundation Scholarship Program.

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ALLERGIC PROBLEMS IN EARLY INFANCY

These problems may be the early signs of more distressing difficulty in later infancy or childhood.

Victor C. Vaughan III, M.D., *Augusta*

THE THREE AREAS in which allergic phenomena are generally conceded to occur with some frequency in the first six months of life are the gastrointestinal tract, the skin, and the respiratory tract. Estimates of frequency, however, are uncertain, owing in considerable measure to lack of common consent as to what clinical phenomena are truly allergic within the normal meanings of that word.^{1,2} Some hesitate to acknowledge allergic states which they cannot demonstrate by direct or passively transferred skin reactivity. Others may propose an allergic etiology for any gastrointestinal upsets or minor skin eruptions for which no better explanation is immediately apparent. Between these two extremes, estimates of the frequency of allergic phenomena in early infancy vary from low to high. Clein³ believes, for example, that one in every 15 infants is allergic to cow's milk alone. The resolution of the question of actual frequency must await further progress in classification and study of observed phenomena in each of the three areas in which quasi-allergic conditions are found. On the other hand, it is not essential that we make any deep commitment to allergic or immunologic theory in order to recognize a consistent body of clinical fact of practical utility, offering us, I believe, frequent opportunity to be useful to certain patients whose difficulties might otherwise go unrecognized and unrelieved.

Gastrointestinal Disturbances

The area in which an infant is likely first to manifest any of the phenomena commonly termed

"allergic" is in the gastrointestinal tract, and the offending agent is almost always a food. These reactions are better called food *intolerances* rather than food *allergies* for three reasons: (1) because only rarely can the usual objective evidence of the anaphylactogenic nature of an offending agent be shown, (2) because the reactive tendency often disappears in a few months, and (3) because the relationship of these reactions to more typical allergic manifestations in later childhood or adult life is uncertain.

Food intolerance in early infancy most typically involves the rejection of the offending material. The baby spits it up, vomits it, or forcefully expels it in diarrheal stools, sometimes with blood, mucus, and eosinophils. He commonly has an apparent distaste for it and manifests other discomfort in the form of irritability, prolonged crying, or colic.

There is a recurring clinical picture, which I believe to be not rare, which with variations is virtually pathognomonic of food intolerance of this type. A hungry, vigorous infant of a few weeks of age is offered a properly prepared bottle containing a formula derived from cow's milk; he sucks once or twice at the nipple and turns his head away with an expression of distaste as if the milk were sour; he cries and remains hungry but accepts the bottle only upon repeated urging. He may empty it partially, only to vomit what he has taken. He may then be able to drain the bottle completely and to retain the formula, but at the expense of an hour or so of more or less continuous colicky distress. Such an infant is almost surely reacting to the ingestion of cow's milk. Careful inquiry may reveal

Presented at the 104th Annual Session of the Medical Association of Georgia, April 29, 1958, Macon, Georgia.

that one of the parents of such an infant also has an intolerance for or dislike of milk. It is generally a waste of time in such infants to attempt to modify the reaction by changing from one form of cow's milk formula to another or from one form of carbohydrate modifier to another. A milk substitute, such as a soy bean preparation or other appropriate substance, should be offered and will generally be eagerly accepted, usually with very prompt improvement in the clinical problem. The maneuver is simultaneously diagnostic and therapeutic.

Inasmuch as cow's milk or some substitute for it is likely to be the basic source of calories in the small infant's diet, it is best when making diagnostic and therapeutic tests to limit the infant's diet to such a basic substance while the test is being made. It is confusing, for example, to change the formula while egg or wheat continues to be fed. Once a satisfactory basic liquid food can be found, the remainder of the infant's diet can be built around it over a period of a few weeks.

The infant with the gastrointestinal reactions described above may also have eczema, and in some infants the eczema may be so severe as to constitute the prime medical problem. A second form of dermatitis⁴ found in those infants with diarrhea or loose stools consists of excoriations in the perianal area, which may be quite tender and easily irritated. These are nestled well within the intergluteal crease, a localization which helps to differentiate them from diaper eruptions of urinary origin. The latter tend to involve the skin in contact with the diaper, sparing the intergluteal fold.

The vomiting infant may have vigorous gastric peristaltic waves indistinguishable from those of pyloric stenosis. But absence of a palpable pyloric tumor, the distaste of these hungry infants for milk, and the prevalence of diarrhea rather than constipation should often lead to a correct diagnosis even when the vomiting is projectile in nature.

Laboratory tests are of little help. If the symptoms can be persistently abolished and recreated when cow's milk is taken from and reintroduced in the diet, the diagnosis of milk intolerance would seem to be reasonably well established. Two further points deserve mention. First, not all milk substitutes are of equal benefit to the baby with this form of food intolerance. Most infants will respond nicely to any of the milk substitutes available, but a few show a decided preference for one or the other. We have found babies who do very well on Sobee[®] who have difficulty on Mull-Soy,[®] and a smaller number of babies of whom the reverse is true. For an occasional infant only Nutramigen[®] or a meat-base

formula will bring satisfactory relief. In the last instance we may presume that intolerance to soy bean substance may be present. It is worthwhile, therefore, where the clinical picture seems strongly to suggest milk intolerance, to try a number of the substitutes in turn before hope of getting relief is abandoned. The second point worth emphasizing is that clinical milk intolerance in early infancy is often temporary. This fact makes it very difficult to sort out from babies with colic which is in some or large measure determined by food intolerance rather than other factors. However temporary the nature of the condition may be, the time of its resolution is uncertain, and if the management outlined above proves helpful, patient and family are often profoundly relieved and grateful.

Finally, we must be aware that a very special form of temporary gastrointestinal intolerance to cow's milk may exist in a few infants in the convalescent phase of an acute diarrheal state of viral or uncertain etiology. Some such infants may have an explosive return of diarrhea if they are given cow's milk, even when they have manifested no intolerance to it prior to the onset of diarrhea. This possibility always ought to be considered in an infant with relapsing diarrhea, and it may be wise always to use a milk substitute prophylactically in the re-establishment of feeding in small infants in whom diarrhea has been especially severe.

Dermatologic Disturbances

It is well known that eczema is of rather common occurrence in infants and young children, and its clinical appearance, its tendency to spontaneous disappearance, and the fact that it is often antecedent to asthma are familiar. It is also widely appreciated that in early infancy eczema a very close relationship to dietary allergens, particularly cow's milk and egg. After eczema has been present for some time, contactants may play an increasingly important role and later on allergens usually regarded as inhalants (such as house dust or pollen) may become predominant factors in keeping eczema alive. In time, eczema may come to be determined by allergens from all these sources—diet, contact, and inhaled particles—and in addition it suffers from a continual tendency to become secondarily infected and becomes increasingly responsive to the emotional state of parent and child.

Altogether, eczema in infancy may present an extraordinarily and increasingly complex problem. Contrary to popular opinion, it is in many cases *not* "outgrown," even with the best available management. It seems reasonable to hope, on the other hand, that the likelihood of remission will be improved if the earliest manifestations are handled with as thoughtful and thoroughgoing care as possible.

Remedies at our disposal include dietary precautions, environmental controls, prompt treatment of superinfection, a variety of topical applications, and continuing emotional support to parent and child.

Allergic eczema must first be distinguished from other skin eruptions. There is a common non-descript irritation of the cheeks or chin of the young infant which is due to lying in regurgitated material or to other contact with a potential or actual allergen, such as orange or tomato. The chest or "drooling area" may be conspicuously involved. Some such reactions can be shown to be the result of direct irritation by allergenic material. On the other hand, many fleeting eruptions in infants are not allergic, but ought to be called miliaria, seborrhea, or unclassified. Many need no therapy. It is without profit to label these as allergic unless systematic study incriminates a specific allergen.

The distinction between seborrheic dermatitis and eczema is sometimes very difficult to draw, and it is indeed felt that eczema and seborrhea are closely related in many infants. The bilateral scaly eruption on the cheeks of the child with seborrheic dermatitis is usually associated with cradle cap, and sometimes with a patchy, reddish, finely scaly maculopapular eruption elsewhere on the body. Seborrheic dermatitis often responds best when treated as if it were a mild infection, with attention focused upon the scalp. The greasy scales of cradle cap are softened with mineral oil and combed or scraped out with a fine-tooth comb. Daily shampoos may be given for a while with a detergent and mildly antiseptic soap, such as may contain hexachlorophene. Very mild sulfur and salicylic acid ointment may also be helpful, as may mild coal tar preparations. At times more intensive therapy may be needed.

Eczema may closely resemble seborrheic dermatitis at its onset, but is more likely to be accompanied by itching and irritability. It often follows by a few hours or days the introduction of a new food into the diet of the small infant. Eczema is rarely related to allergens contained in maternal milk, but in the unusual instance where these substances appear in sufficient quantity in maternal milk to affect the infant, the mother ought easily to be able to avoid them in her own diet.

While cow's milk is probably the most common precipitating allergen in eczema, egg is generally the most violent. Hill⁵ believes that eggs bear a particularly close causal relationship to eczema in infants. Infants will occasionally be found whose reactivity to egg is so great that they need to be kept out of the kitchen where eggs are routinely used, and cannot be handled by the mother who has cooked with them unless her hands have been very carefully washed. Under these circumstances it seems reason-

able to suggest that eggs be introduced infrequently into the house and very late into the diet of an eczematous infant.

In eczema, as in those gastrointestinal problems where cow's milk seems a likely offender, the surest diagnostic and therapeutic test will be to reduce the diet to the barest essential—a milk substitute. Here again, one substitute may be preferred to another by a particular infant. If a satisfactory milk substitute can be found, other items of diet such as meats, fruit, and the like, may be added cautiously after the age of three to four months. Protection from such potent potential environmental allergens as house dust, wool, and feathers ought to be, inasmuch as possible, a continuous aspect of home life for the child with eczema.

Local therapy in eczema begins with restraint of the infant, if necessary, so that scratching will be minimized. Antibiotic medication will be indicated if there is a purulent, oozing, or crusted eruption, since skin so involved is surely infected very often with the hemolytic streptococcus.⁶ In such instances lymphadenopathy and splenomegaly may be conspicuous. Oral administration of penicillin in high doses is recommended, or occasionally some other drug, according to results of study of the bacterial flora. Local care of acutely infected eczema should be limited to soaks of Burow's solution or saline solution until the skin is clean, when a mildly antiseptic paste may be used as Lassar's paste in a water-soluble base with added benzalkonium or hexachlorophene. *Local* antibiotic therapy is strongly contraindicated, except for the occasional sparing use of ointments or soaks containing bacitracin or neomycin. When the skin is dry and is without infection or acute irritation, mild coal tar preparations may be used. Topical administration of hydrocortisone is rarely indicated, and systemic steroid therapy is very rarely indicated.

Two very practical points may greatly influence the course of eczema in early infancy. One is that when the condition becomes especially weepy and crusted, it ought to be promptly recognized as secondarily infected with bacteria and treated as outlined above; secondly, that two specific viruses, those of vaccinia and herpes simplex, may cause very severe generalized, and sometimes fatal infection when implanted on eczematous skin. The infant with active eczema should not be vaccinated against small pox nor should any one in his household be vaccinated unless the vaccinated person can be rigidly isolated from him. The query should be routine at every vaccination as to whether there is a child with eczema or other generalized skin eruption with whom the child to be vaccinated has contact. Prevention of eczema herpeticum is less certain, but

separation of persons with fever blisters and undifferentiated respiratory infection from the infant with active eczema makes sense prophylactically both for bacterial and potentially herpetic viral problems.

Respiratory Disturbances

In early infancy the respiratory system⁷ is less often the site of allergic or quasi-allergic reactions than the gastrointestinal tract or skin. The most common respiratory conditions of the first six months of life which appear to depend upon allergic factors are a persistent rhinorrhea and an excess of mucus in the bronchial tree, either of which may occur with a chronic cough. These symptoms are often of such severity as to interfere with the infant's sleep or feeding activity, and are usually due to infection. Sometimes the infant simply seems to have one cold after another. Persistent irritability and associated gastrointestinal symptoms are common. Absence of fever is usual unless secondary infection supervenes. Such respiratory symptoms must be shown not to be due to anomalies of the cardiorespiratory system, to fibrocystic disease, or to unusual frequency or conditions of exposure of the infant to infectious agents.

Asthma is rare before the age of six months, though an increasing number of infants before and after that age will present the syndrome of bronchiolitis. In some of these the *repeated* association of lower respiratory obstruction with respiratory infections will first suggest and then in later years prove to be asthma. Spasms, exudation, and edema in these infants are the elements of the allergic reactions, and may first appear not in the bronchi but in the laryngeal area, as spasmodic croup. Allergic study is suggested in infants with repeated episodes of either spasmodic laryngitis or of bronchiolitis.

Here again, foods and especially cow's milk, are prime offenders in earliest infancy, and again the diagnostic and therapeutic procedure is to give a milk substitute. Late in the first year and increasingly thereafter, inhalant factors may perpetuate the early problem. Infants in whom early respiratory congestion depends upon foods may show increasing susceptibility to frequent or chronic upper and lower respiratory infection as they grow older. Inhalant allergens become increasingly important factors, and undifferentiated infection of the upper respiratory tract a potent trigger setting off the clinical reaction. Chronic sinusitis and otitis media are common in such infants or children and lead to enlargement of lymphoid tissue in and about the upper respiratory tract. If the allergic element is

unrecognized, prolonged attempts at control of these chronic problems will be disappointing, even though the attempts may include multiple courses of many different antibiotic agents and often, as a last resort, tonsillectomy and adenoidectomy. In these children tonsillectomy and adenoidectomy based only on vague hope of abating a nuisance are strongly contraindicated, and even when otherwise normally indicated, should be undertaken hesitantly, since the removal of these tissues may precipitate the emergence of asthma in a child who has not previously had it where underlying and unsuspected allergic factors can be brought under control. Moreover, adequate allergic therapy often abolishes apparent need for tonsillectomy and adenoidectomy.

In early infancy the preponderance of reactivity to foods again makes diagnosis and therapy relatively easy; they consist of elimination diets. Only in later infancy or childhood will skin tests be likely helpful, and in the respiratory allergies to a greater degree than in gastrointestinal problems or eczema. When tests do become useful, it will be the reactions to house dust and other inhalants, pollen, molds, and a few common foods which will be of most help.

General Considerations

In each of the conditions reviewed above, certain general considerations stem from the fact that the involved infant has a demonstrated tendency to react in an abnormal manner to supposedly innocuous material. Observers agree that there are some foods or other substances commonly encountered which are more likely than others to cause such reactions. The foods are cow's milk, egg, wheat, chocolate, tomato, citrus fruit, seafood, and certain others. While the young infant is unlikely to ingest some of these, it seems reasonable to suggest further that the inevitable ultimate exposure to these substances of high sensitizing potential should be postponed as long as possible. It is easy and completely safe, for example, not to feed the allergic infant egg, wheat, chocolate, tomato, or citrus fruit. It is harder and more expensive to avoid cow's milk, but some forms of cow's milk are less allergenic than others. We have commonly seen the onset of gastrointestinal or skin difficulties coincide with a change from evaporated milk to fresh cow's milk. Only rarely will the latter be better tolerated. In general, we should urge, therefore, that in infants in whom we have demonstrated the kind of allergic reactivity we have discussed, a hypoallergenic form of milk such as evaporated milk ought to be given for as long as possible, up to two or three years of age. This seems reasonable also for the infant born into an allergic family. The remainder of the diet should be a well-balanced choice of substances of low sensitizing po-

tential such as meats, cooked or canned fruits, green vegetables, oat or rice cereals, and the like, with vitamin supplementation as usual. The dietary program may seem a nuisance but it is not really cumbersome and surely not unhealthy, unless the parents become too restrictive or are made unduly anxious by their concern that infants and children simply *must* have milk or eggs. The physician's responsibility will be to appraise continuously the infant's clinical problem, diet, environment, and home situation. He should offer support, suggestion, and education in such a manner as to give most relief of present symptoms and least opportunity for their recurrence or for emergence of new ones. He must do this at least cost in effort or anxiety, bearing in mind both the caution that the allergic conditions of early infancy may be the early signs of more distressing difficulty in later infancy or childhood, and the

reassurance that they are in many cases only temporary nuisances.

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INCREASED HEALTH INSURANCE FOR AGED

MORE THAN THREE out of every eight persons 65 or over in this country now have some form of voluntary health insurance, Health Information Foundation reported today. The proportion of the aged population with such insurance increased about 50 per cent from 1952 to 1957.

In the January issue of its statistical bulletin, *Progress in Health Services*, the Foundation published first results of a study made in cooperation with the National Opinion Research Center of the University of Chicago. A random cross-section of the population 65 and over, 1,700 persons in all, were interviewed at length about such items as their health, living arrangements, and incomes.

Largely because of modern medical science, the number of aged persons in this country is increasing at a somewhat faster rate than the population at large. At present, the Foundation pointed out, there are an estimated 15 million persons 65 and over in the U. S., and the number is expected to reach about 25 million by 1980.

Thirty-nine per cent of the aged carried some type of voluntary health insurance at the time of the interviews. Almost all the insured (at least 93 per cent) had hospitalization insurance, while two-thirds of the insured were protected against in-hospital doctor bills and 21 per cent were covered against physicians' out-of-hospital charges.

Three out of four insured persons bore the entire cost of the coverage themselves, at an average (median) cost of \$4 a month. Other sources of payment included present or previous employes,

children or other relatives, and trade unions or fraternal orders.

Less than three per cent of those interviewed had tried to buy health insurance and been turned down, according to H. I. F. More than one-fourth of the uninsured had never thought of getting such insurance, while almost as many said they didn't want it. Thirty-four per cent of the uninsured said they couldn't afford it; 16 per cent said they didn't believe they were eligible for it.

The Foundation reported that two-thirds of the aged population said they would like insurance that covered all medical expenses. The median amount they indicated they were willing to pay came to \$5 a month.

Just over half the people in the 65-and-over group favored government insurance that would pay hospital and medical expenses. Among these, however, almost half wanted such insurance only for "needy" persons.

Although the number of aged persons covered by voluntary health insurance has increased significantly in the last few years, the Foundation report continued, further study in this area is needed—and other persons themselves must show greater interest in securing insurance.

"Plans for financing health needs of the aged may vary," the report stated, "but all should agree on one point: that a group of older persons responsible for their own health is an asset to society—and in keeping with present attitudes toward independent active later life for all."

PRESENT STATUS OF SYNTHETIC ARTERIAL GRAFTS*

J. Harold Harrison, M.D., *Atlanta*

A teflon prosthesis is definitely preferable to a homograft for replacing segments of vessels larger than iliac arteries in man.

THE RAPID EXPANSION of the field of vascular surgery during the past decade has markedly increased the need for arterial substitutes. Homografts have played a major role but the somewhat limited supply, the expense involved in procuring and storage, and recent evidence that there is breakdown with aneurysm and rupture after long periods of implantation make them less than ideal. Synthetic prostheses, if proven satisfactory, possess many advantages including an adequate supply in a variety of sizes and shapes, ease of storage, and resistance to breakdown after implantation.

In a comparative study of synthetic prostheses and homografts in over 400 animals, it became apparent early that the results varied directly with the size of the vessel replaced. When vessels over 9 mm. in diameter are replaced, the results with any synthetic material are so good that they might be misleading. There was occlusion of only one of 82 grafts of nylon, dacron, orlon, teflon, or ivalon sponge replacing segments of the thoracic aorta of dogs.^{4,5}

As the diameter of the graft decreases below 9 mm. maintenance of patency is the primary problem and small variations in the grafts become more apparent. This is explained by a review of the fate of a synthetic graft after implantation. Following the release of the occluding clamps, there is bleeding through the interstices which stops after one to four minutes. The graft becomes enclosed in a fibrous capsule that gradually becomes adherent. A layer of fibrin is deposited on the inner surface. This is loosely attached and increases in thickness to 1 to 3 mm. by three weeks (Figure 1A). The fibrin lining is

then replaced by fibrous tissue growing through the interstices of the graft (Figure 1B). The healed graft has a thin, smooth, glistening inner surface grossly like the intima of the host artery (Figure 1C).

Occlusion when it is to occur, does so when the fibrin is present and rarely after it has been replaced by fibrous tissue. The average time of occlusion of grafts in this series was 16 days and none became occluded after 60 days. The thickness of the fibrin lining is independent of the diameter of the graft. As the diameter decreases there is a proportionally greater reduction in the size of the lumen and blood flow increasing the chance of occlusion from a superimposed thrombus. A 2 mm. lining that would make little difference in the flow through a 12 mm. graft would practically occlude one 6 mm. in diameter.

There are individual variations in animals that

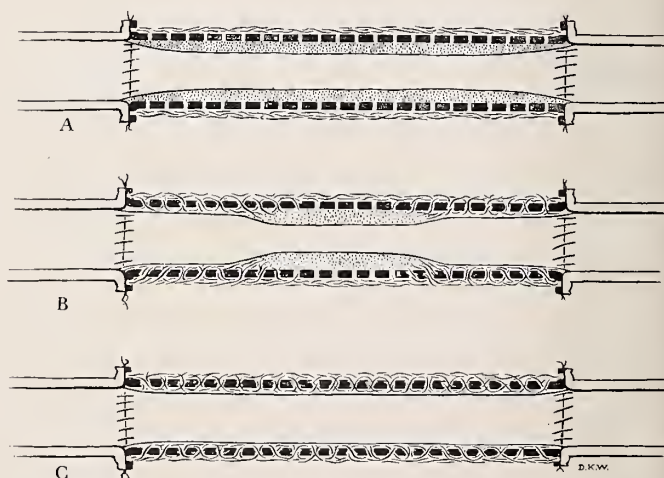


Figure 1: Schematic drawings of fate of synthetic graft. A, fibrin layer is deposited on inner surface, the thickness varying with the material but independent of the diameter. B, fibrin is gradually replaced by fibrous tissue growing through interstices of weave of graft. C, inner surface of healed graft is covered by thin layer of fibrous tissue grossly similar to intima of artery. Occlusion, when it is to occur, does so when fibrin is increasing in thickness and rarely after it has been replaced by fibrous tissue.

*From the Joseph B. Whitehead Department of Surgery, Emory University School of Medicine, Atlanta, Georgia. Supported in part by Research Grant No. DA-49-007-MD-886, Research and Development Division, Office of the Surgeon General, Department of the Army, Washington 25, D.C.

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cannot be explained but in general the thickness of the fibrin lining deposited on the inner surface can be correlated with the chemical stability, wettability, and the amount of tissue reaction incited by the graft.

Physical and technical factors, including the method of preparation, technique of insertion, porosity and smoothness of the inner surface become of more importance. A uniform continuity of flow from the proximal to the distal artery through the graft is imperative. Any interruption of this will cause an encroachment on the lumen and an increase in the thickness of the fibrin lining due to changes in the blood flow. Either or both factors might be sufficient to occlude the lumen of a small graft.

In a comparative study, grafts of nylon, dacron, orlon, ivalon sponge, and teflon 6 to 8 mm. in diameter with a wide range of physical properties were inserted into defects created in the abdominal aortas of 133 dogs. The results are outlined in Table I.

There was occlusion of 50 per cent of the nylon sewn grafts and 30 per cent of the crimped tubes (Table I). The fibrin lining deposited on the inner surface of the nylon grafts reached 2 to 3 mm. in thickness and healing, while complete in some by three months, was not in others after one year. These factors are responsible for the high rate of occlusion in small vessels. There was a marked acute and chronic foreign body reaction incited by the nylon and fibrosis around the grafts was more extensive than with any of the other materials (Figure 2A). The results indicate that nylon is unsatisfactory for replacing small vessels.⁴

Fifty per cent of the dacron sewn grafts became occluded by thrombosis (Table I). The fibrin lining deposited on the inner surface reached 1 to 2 mm. in thickness and healing was complete in most by four to six months (Figure 2B). Dacron is considered superior to nylon but still unsatisfactory for replacing small blood vessels.⁴

TABLE I
Observations with Homografts and Synthetic Grafts Replacing
Segments of Abdominal Aorta

Type of Graft	Diameter of Graft (mm.)	No. Followed	No. Occluded	Per Cent Occluded
Nylon weave sewn grafts	6-8	13	7	50.0
Crimped nylon tubes	8	11	4	30.0
Dacron weave sewn grafts	6-8	24	12	50.0
Knitted orlon tubes	8	15	5	15.4
Molded ivalon sponge	6-7	9	2	22.2
Woven teflon tubes (purified)	6-8	19	2	6.3
Homografts	6-8	10	1	10.0

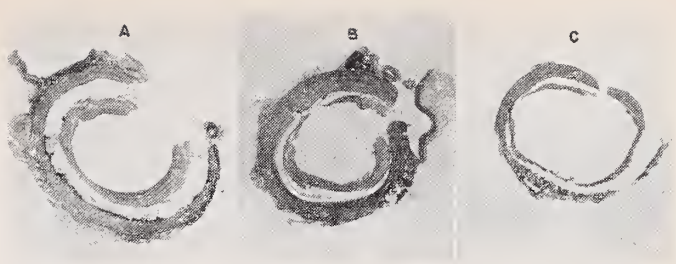


Figure 2: Photomicrograph of cross sections of grafts at 30 days. Original magnification X 4. Fibrous tissues encloses grafts and fibrin lines inner surface. Part of the plastic separated at the time of sectioning. A, nylon; note thick fibrin lining of inner and fibrous enclosure of outer surface. B, dacron; fibrin lining is slightly thinner than nylon. C, teflon; note thinness of fibrous and fibrin layers compared to nylon and dacron grafts.

There was occlusion of 22.2 per cent of the ivalon sponge grafts. The ivalon sponge became hard and brittle and there was a fusiform aneurysm in one and a dissecting aneurysm in another at six months (Table I). Ivalon sponge is chemically unstable and is somewhat soluble. Both are responsible for its rapid breakdown and makes it unsatisfactory as a vascular prosthesis.¹

Fifteen grafts of knitted orlon tubes advocated by Dr. Sanger were followed with complications in 13. The grafts are too porous, resulting in delayed bleeding through the interstices and hematomas surrounding the graft (Table I).³

The best and only satisfactory results were obtained with woven purified tubes of teflon. There was occlusion of 6.3 per cent of these which compares favorably with the 10 per cent occlusion rate in a series of homografts (Table I). The teflon grafts had fibrin linings of less than 1 mm. in thickness and healing occurred in most by one to three months (Figure 2C). In addition, the healed teflon grafts were enclosed in a thinner layer of fibrous tissue making them more pliable (Figure 3).²

There was occlusion of 90 per cent of the purified teflon grafts 4 mm. in diameter replacing segments of the femoral arteries of dogs.⁴

Teflon, chemically the most inert synthetic material known, is practically non-wettable and incites

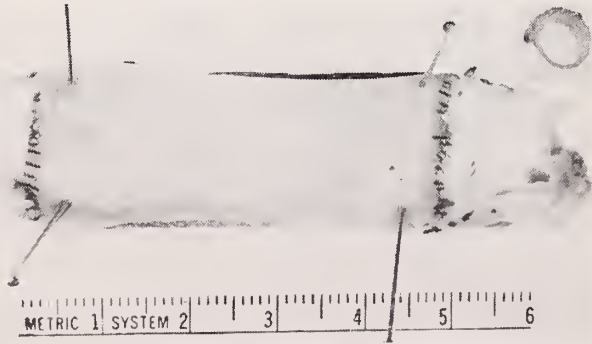


Figure 3: Teflon graft at 120 days open view and cross section. Complete healing has taken place and graft is enclosed in thin layer of fibrous tissue.

much less tissue reaction than any of the other plastics studied. These factors are responsible for the thinner fibrin lining that is deposited, more rapid healing, lower rate of thrombosis, and thinner fibrous enclosure with more pliability of the healed grafts.

Seamless tubes gave better results than those with a longitudinal seam prepared on a sewing machine. They can be inserted with smoother anastomotic lines and there is less tendency to wrinkle, either of which will increase the rate of thrombosis.⁴

Experience with the technique of insertion is imperative if good results are to be obtained with any synthetic material replacing a small blood vessel. Irregularities in the suture lines should be avoided, and they should be inserted under slight tension as loosely inserted grafts will buckle, causing a higher rate of occlusion.⁴

Solid tubes will not remain patent and there will be excessive bleeding through grafts that are too porous. Between these extremes the desirable limits of porosity have not been established. Our studies indicate, however, that within given limits this is not as important as the material making up the graft.⁴

It is doubtful that a small difference in the smoothness of the inner surface of a graft is as important as the other factors. During the first 24 hours this might be significant, but after this time fibrin fills in all small defects and the original differences in smoothness are eliminated.⁴

Large Vessels

When vessels larger than 9 mm. in diameter are replaced, maintenance of patency is no problem.⁵ Of primary concern in these is that the walls of the grafts be of sufficient strength to prevent

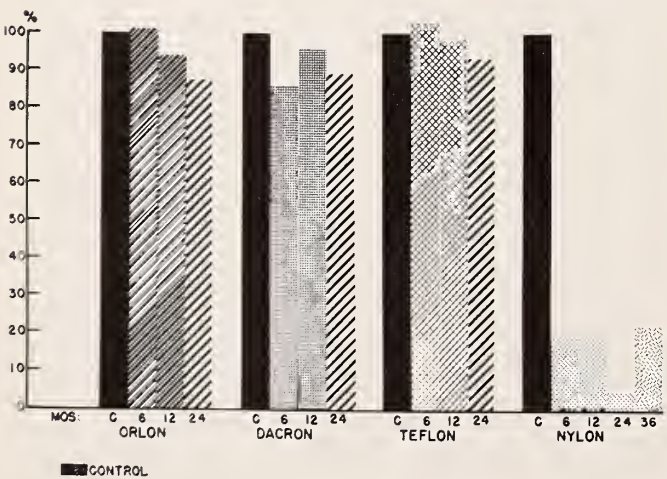


Figure 4: Comparision of tensile strength of plastic grafts. There was little change in strength of the arlan, dacran, or teflon, while there was almost complete breakdown of nylon during the periods of observation.

Figure 5-A



Figure 5-B

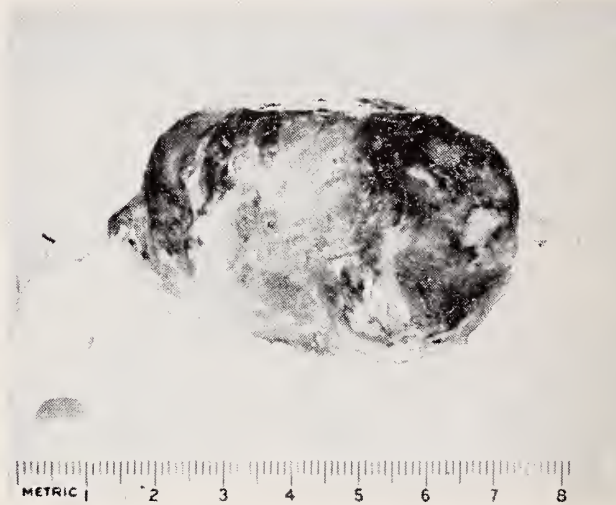


Figure 5: Woven dacron graft at two years. Outer (A) and opened (B) views. The graft is enclased in an encapsulated hematoma. The outer portion of this is old and partially organized while the inner portion is soft and of more recent origin. The graft is intact and healing has taken place across both suture lines. The inner surface is otherwise bare and water placed in the lumen flowed freely through the interstices. See text.

aneurysm and rupture. The plastic becomes enclosed in a network of fibrous tissue. This tissue will add support but it is not sufficient to prevent aneurysm or rupture should the plastic itself break down.

The loss of strength of a synthetic after implan-tation in the body is due primarily to chemical de-gradation. The synthetic material should, therefore, be initially strong enough to withstand the forces of the blood stream and sufficiently inert that it will maintain this strength after implantation for a long period of time.

Tensile strength determinations were made of the materials before and after implantation as vascular grafts in the thoracic aortas of 82 dogs for two to three years. There was a rapid loss of strength of nylon and ivalon sponge, leading to aneurysm and

rupture of the grafts. Teflon, dacron, and orlon lost little or none of their strength during the period of observation (Figure 4).

In animals sacrificed at two years there were hematomas around the grafts of nylon, dacron, and orlon. These were enclosed in a thick layer of fibrous tissue. The outer portion of the clots were old and partially organized but the inner portions were soft and of recent origin. The grafts were intact and water placed in the lumen flowed freely through the interstices (Figure 5). Similar complications were not observed at intervals up to one year with the same material. Why this occurred at two years is yet unexplained. Teflon grafts were well healed and no complications were encountered after two years.⁶

Nylon and ivalon sponge are somewhat chemically unstable which is responsible for their breakdown when implanted in the body. The results indicate that they are unsatisfactory as vascular prostheses.^{1,7}

Dacron and orlon maintain their strength after two years. The occurrence of delayed bleeding through the interstices of grafts of these materials indicate the need for further study before they are widely accepted for clinical usage.⁶

Grafts made of teflon are the only ones in which complications did not occur after two years. It should because of its greater chemical inertness maintain its strength longer than any of the other materials.

These and other studies indicate that a teflon prosthesis is definitely preferable to a homograft for replacing segments of vessels larger than the iliac arteries in man. They are well tolerated and will maintain their strength over a longer period of time. This is likewise true for replacing short segments of vessels the size of the femoral arteries. Previously, homografts have been considered prefer-

able for replacing long segments of vessels the size of the femoral artery and smaller, particularly when they crossed flexion creases. The only teflon grafts available were woven tubes that might buckle or kink under such circumstances increasing the incidence of thrombosis. A knitted, crimped teflon tube has recently been developed that eliminates this undesirable feature. Experimental and clinical evidence to date are not sufficient to draw definite conclusions, but indicate that they will maintain their patency. With this accomplished, they should be superior to homografts for replacing vessels larger than 5 mm. in diameter.

No synthetic graft less than 5 mm. in diameter yet studied has been satisfactory. Homografts and vein grafts are preferable for vessels this size and the results with them should not be expected to be good.

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NEW HEART FILM AVAILABLE

"CONGENITAL HEART DEFECTS," latest film in a series on the cardiovascular system and its diseases for presentation to professional workers, students, and the general public, is now available from local Heart Associations or from the American Heart Association on a rental or purchase basis.

In explaining the underlying physiology of a number of congenital heart defects, the film, like others in the series, makes effective use of animation. The structure of the normal heart and how it works are shown in animated diagrams. Five common defects that may be helped by surgery are con-

trasted with the normal heart. These include patent ductus arteriosus, coarctation of the aorta, valvular pulmonary stenosis, tetralogy of Fallot, and an arterial septal defect.

Earlier films in the series, produced for the American Heart Association and its affiliates by Churchill-Wexler Films, are: "Varicose Veins," "Circulation of the Blood," "High Blood Pressure," "Strokes," and "Coronary Heart Disease." All of the films, which are 16 mm. and run under 10 minutes, are cleared for television use.

Augusta Welcomes the Medical Association

Elizabeth J. Thompson, M.D. and Mrs. Joyce Young, *Augusta*

AUGUSTA HAS MANY CONVENTIONS each year, but she is always indeed proud when the Medical Association of Georgia convenes here. Augusta is one of the fastest growing cities in the State and has achieved much in the past few years. To enumerate some of the achievements of this friendly city will sound like boasting. Well, to be honest about it—it is boasting, but we can't help it!

We are proud to claim Fort Gordon (formerly Camp Gordon during World War II) as the Signal Corps Headquarters and the new 4-lane highway built to connect it to the heart of the city.

The recently opened Eugene Talmadge Memorial Hospital has added much prestige to the city, to the Medical College of Georgia, and to the entire medical profession in Augusta and throughout the state. Adjacent to this fine hospital are many new buildings composing the ever-progressing Medical College of Georgia.

Then, several times a year, this expanding city is sought-out by the President of these United States as a refuge for relaxation on the beautiful grounds of the Augusta National Golf Course located on the west side of town. During these times, the White House is transferred to "Mamie's Cabin" and all the eyes of the Nation and the world are focused on Augusta, Georgia.

Each Spring, the nation's best male golfers match talent and precision in the well known Masters' Golf Tournament which is played on the Augusta National Golf Course. A few weeks earlier the female golfers of the nation congregate at the Augusta Country Club to compete in the Titleholders' Golf Tournament.

In the very near future, Augusta will be an active inland port, as the Savannah River is now being dredged so that barges may more easily use this waterway in transporting various commodities.

On the south side of town, land is being readied for construction of a branch of The Continental Can Company.

In the past few years, two fine suburban shopping centers have been developed, Southgate Plaza on the south side of the city and Daniel Village on southwest side of the city.

We are indeed, very proud of our clean and efficient airport known as Bush Field located on the well known Tobacco Road, which is only a short drive from downtown Augusta. In addition to being clean and efficient, it is also very appealing and relaxing because of its modern design and facilities.

About 30 miles from Augusta the Corps of Engineers built Clark Hill Reservoir which has a little over 1,000 miles of shore line. Needless to say, boating, fishing, and water skiing are very popular sports for many Augustans and our nearby Georgia and South Carolina neighbors. The development of many camping and picnic areas is rapidly progressing. In addition to several docks for power boats, there is a sailboat basin and an enthusiastic Sailboat Club. The Motorboat Club of Augusta is also quite active.

The multi-million dollar E. I. duPont de Nemours' Savannah River Plant built in nearby South Carolina brought hordes of temporary construction workers to this area. The site was chosen because of the natural elements found in the Savannah River water which are necessary in the production of "heavy water." Thousands of permanent workers will remain in the Savannah River section as witness to a recent 112 million dollar grant to the plant by the government for expansion.

Augusta has long been known for its textile industries and brick manufacturing which are still productive.

Among many other things, Augusta is very proud of the many beautiful gardens which are opened each spring to the public and a tour of these lovely gardens is most enjoyable.

There are several organizations here that provide some of the finest entertainment in the fine arts category. Well known performers in the fields of music, drama, and art are brought to Augusta each year.

Yes, we too, are proud of our historical landmarks found throughout the city and many are being preserved and restored. As the status of each city of any stature is measured not only in the present, but in the past, we are proud of our role in the history of Georgia and the nation.

When George Washington was this infant nation's first elected leader, he paid a visit to this city on the banks of the broad Savannah River at the head of its navigable waters. He came by water landing approximately where Bush Field is today and came in by Tobacco Road.

Augusta's links with the past may be seen on all sides—from the "Street of Monuments," some call Greene Street, to the large shaft on the banks of the canal pointing out the site of the old War Between the States' Powder Mill.

"Meadowbrook," the home of George Walton, one of the Georgia signers of the Declaration of Independence, still stands, as do many fine examples of ante-bellum architecture.

On lower Greene Street, a shaft of granite in a center, well-kept park-way, demonstrates the pride Augusta has in her three Declaration of Independence signers. Under that shaft are buried George Walton and Lyman Hall, but the fiery Button Gwinnett, lover of quarrels and duels, is buried in an unknown grave. Recently, Augusta thought the Gwinnett bones had been discovered and immediately put in a bid for them. Medical records proved these were a hoax and the mystery of his last resting place has not yet been solved.

Augusta's fine canal system, launched before the War Between the States, is still serving the large textile mills clustered on its three levels. It is still acclaimed as a marvel of engineering skill.

On upper Broad Street, perched above the busy street, is a vast step back into the past in the shape of the little White House. The walls of this Revolutionary fort are still thick and earthen-filled to stop shot. Some say on a still night the screams of the patriots being slaughtered by the Tories and the Indians may still be heard.

Broad Street still remains the largest main street in the South. There will be some to rise and say Canal Street in New Orleans is wider. Yes, a matter of inches, but the Augusta main artery is the widest in terms of the area being used. Augusta's Broad Street permits the parking of cars both in the center and at the curbs on both sides, and yet offers three lanes of traffic on either side. Can Canal Street top that?

At one time Augusta was the proud Capital of Georgia. Records do not show where the Capitol was located, but vague mentions are made to a site near the river.

When General Sherman became desirous of cutting a wide swathe through the state, he avoided Augusta. This detour in his line of march has brought up many interesting speculations including the burial of Sherman's daughter on the Augusta Arsenal Grounds, and the presence of a belle who

won his heart. But the hard-headed historians point out that taking and wasting Augusta would have been a costly project as many of the Confederate troops pulled in here after the Battle of Atlanta, and were well supplied from the large powder works.

Augusta is a city of churches. Hardly a section lacks its own imposing edifice with its spires pointing proudly heaven-ward proclaiming "this is not a Godless community." All denominations are represented, and the pastorates are filled with learned and renowned men.

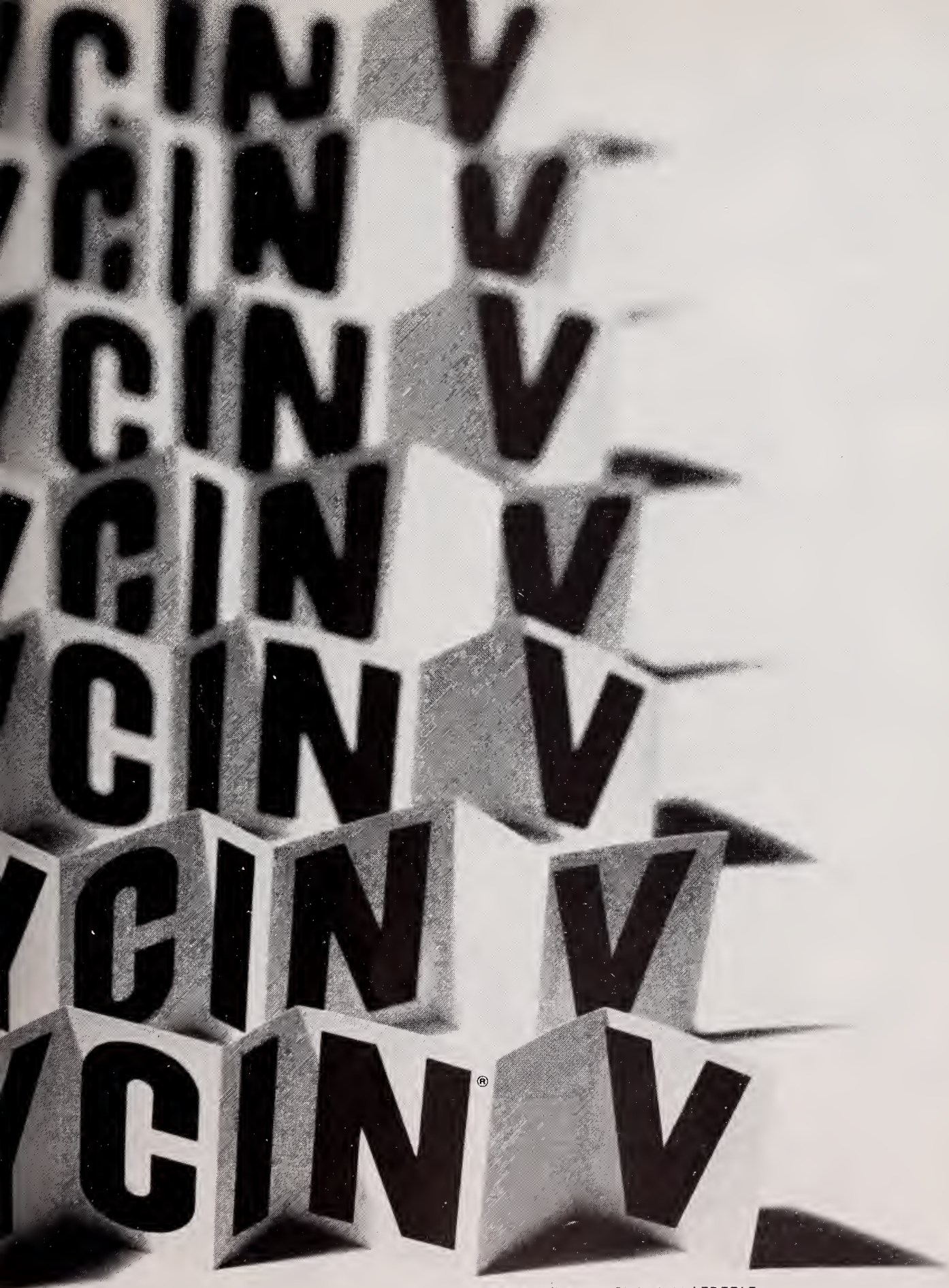
Again we will briefly touch on the hospitals. For many years it was the dream of the city fathers to make Augusta a medical center. When Governor Herman Talmadge set the wheels in motion to erect the state hospital here and name it for his father, that dream became a reality. For the new hospital, its many accompanying buildings, plus the new classrooms for the Medical College of Georgia, turned University Place into a vast, busy medical center that has attracted many allied buildings adjacent, such as motels for families of patients, and medical office buildings for doctors and dentists. Located elsewhere, but having access to the up-to-date medical facilities, are veterans hospitals—the Lenwood for mentally ill veterans and the Oliver General for general cases.

With the population nearing the 100,000 mark, Augustans are predicting they will soon inch Richmond County out of the number six position she holds in the state to a slot somewhere near Fulton's number one. The prediction hinges on the assertion that Augusta has fine homes, churches, up-to-date schools, recreational facilities both at home and on the Clark Hill reservoir where hunting, boating, and fishing are the finest in this section.

Actually, when describing the natural advantages of this city, it is easy to become carried away. For when General Oglethorpe sent his men up from Savannah to locate a post at the head of the Savannah River's navigable waters, the loveliest site was selected. Growing naturally, the city filled the bowl at the river's side and then progressed up the hill-sides where many fine home sites offered surroundings free from the dust and smoke that industrial progress breeds. The lighted city, when viewed at night from the encircling hills, is a thing of beauty. A happy combination of air, rails, and highways, with the coming addition of a nine-foot channeled river, places Augusta within hours of the major cities of the southeast.

Again, we extend our heartfelt welcome to the physicians of Georgia, their wives and the guest speakers who will gather here for the Annual Session of the Medical Association of Georgia.

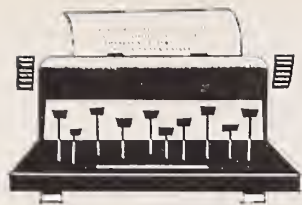




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editorials

Annual Session, Augusta, 1959

ALL ROADS WILL LEAD to Augusta for the doctors of Georgia on the week-end of May 17. On this date the 105th Annual Session of the Medical Association of Georgia will get underway.

This year's program promises to be outstanding in all departments. Well known speakers have been secured from all parts of the country and the topics they will discuss embrace a wide spectrum of interests and specialties. It is interesting to observe how many physicians of note from within our state are included in the program of scientific papers and panel discussions. Lustre will be added to the meeting by the appearance on the program of the president-elect of the American Medical Association as well as the Governor of Georgia. By scheduling the Annual Session for a later date this year than ever before, many conflicts with national meetings have been avoided. This is reflected in the increased number of excellent speakers to be seen on the program. By avoiding conflict with other meetings,

it is anticipated that more doctors within the state will be able to attend the Augusta meeting.

Besides the intellectual stimulation presented at such a session, we all have a duty to be in attendance so that the decisions of our House of Delegates will truly reflect the will of the majority of doctors. We owe it to our elected delegates to counsel with them frequently and make known our opinions on the many issues which are decided by this body.

As in the past, the Local Arrangements Committee in Augusta has planned a most attractive program of social activities to add zest to the meeting. Specialty society luncheons and dinners have been scheduled as well as alumnae dinners for graduates of the two schools of medicine within the state. For those physicians with thermo-nuclear inclinations, a tour of the Savannah River Atomic Energy Plant has been arranged.

All in all it appears to be a great meeting in prospect. We hope to see you there.

"Doc Mag Says" Column One Year Old

MAG'S WEEKLY HEALTH COLUMN Committee completes its first year of work this month under the able chairmanship of H. C. Derrick of La-Fayette. The Committee has prepared more than 50 articles on health subjects which have been mailed to Georgia's 200 weekly newspapers. These articles are mailed every Monday from the MAG Headquarters Office.

More than 150 of the newspapers have run one or more columns under the title "Doc Mag Says." Topics of columns have been of general interest such as nerves, heart, cancer, and also have been

concerned with specific diseases and medical problems.

The Journal wishes to take this opportunity to commend the work of this fine committee and to wish it success during the next 12 months. Literally hundreds of thousands of readers have been exposed to these health columns and we feel that the committee is doing a great public service. As members of the fourth estate ourselves, we wish to congratulate these weekly newspapers who have participated actively in the "Doc Mag Says" program.

Prophylactic Antibiotic Administration, A Menace?

THE PROPHYLACTIC USE of therapeutic doses of antibiotics has gained widespread use in the last 12 years. In certain instances where sterilization of the gut is desired such as in hepatic coma to prevent bacterial breakdown of urea to form ammonia, therapeutic doses of broad spectrum antibiotics employed prophylactically are useful. In many other situations they may be not only useless but harmful.

Weinstein and collaborators have pointed out the danger of treatment of untreatable diseases such as coryzas with broad spectrum antibiotics. Superinfection with a partially or completely resistant organism may ensue about the fifth day of treatment converting a benign, self-limited disease into a serious, prolonged or even fatal one. Organisms not ordinarily invasive such as staphylococci, monilia, and many types of gram negative bacilli may overwhelm the body with a fulminating generalized infection usually beginning in the intestinal tract. This was seen in some of the earlier cases of nephrotic syndrome treated with ACTH® or Cortisone® in which therapeutic doses of antibiotics were used prophylactically.

Patients with indwelling catheters in whom these agents are utilized often emerge with a resistant proteus infection which clears only after the antibiotic is stopped. Thus some infections are actually antibiotic dependent. Treatment of infections accompanying renal calculi or urinary obstruction without removing the obstruction also may encourage development of a proteus infection.

Ivan Bennett and collaborators have demonstrated most effectively the folly of trying to prevent pneumonitis, urinary infections, etc. by using antibiotics in unconscious people. Pneumonitis occurred in 45 per cent of the treated subjects and

in only 15 per cent of the untreated. Gram negative rods replaced the normal nasal flora. Urinary infections with resistant organisms appear.

The monilial and staphylococcal enteritides which accompany administration of broad spectrum antibiotics are familiar to all physicians. The staphylococcal infections may not respond to specific therapy until the original medication has been discontinued.

Prophylactic use of large doses of antibacterial agents prior to cystoscopic examination may lead to development of infections by organisms which do not respond to any therapy and which in some instances have lead to the death of a patient from an otherwise safe procedure.

Good surgeons are now relying upon meticulous technique to prevent surgical infections using antibacterial drugs only when infections appear. They find it easier to manage the infections which occur without the antibiotics than the resistant ones which appear with them.

Our current dilemma with resistant staphylococcal disease can be traced directly to wide indiscriminate use of antibiotics.

Many benefits are derived from proper use of these agents but indiscriminate use prophylactically or even therapeutically in untreatable virus infections may bring disastrous consequences.

A. J. Merrill, M.D.

REFERENCES

1. Weinstein, L.; Goldfield, M.; and Chang, T.: Infections Occurring During Chemotherapy, *New Eng. J. Med.* 251: 247, 1954.
2. Metocoff, J.; Rance, C. P.; Kelsey, W. M.; Nakasone, N.; and Janeway, C. A.: Adrenocorticotrophic Hormone (ACTH) Therapy of the Nephrotic Syndrome in Children, *Pediatrics* 10: 543, 1952.
3. Petersdoff, R. G.; Curtin, J. A.; Hoefrich, P. D.; Peeler, R. N.; and Bennett, I. L., Jr.: A Study of Antibiotic Prophylaxis in Unconscious Patients, *New Eng. J. Med.* 257: 1001, 1957.

TWENTY YEAR RADIATION STUDY PROPOSED

THE COMMITTEE ON PATHOLOGICAL Effects of Atomic Radiation of the National Academy of Sciences has proposed a twenty-year study in the United States of the effects of radiation on human beings. Two groups of about a million persons would be studied under the proposal. One group would consist of those living in an area known to have a high radiation incidence from cosmic rays, while the

other group would be in a sea level area of low radiation incidence. In addition to natural background radiation, other sources such as X-rays and radio therapy would be taken into consideration in the study. Estimated to cost \$750,000 to \$1,500,000 annually, the study will be proposed to Congress within a year.

current clinical concepts

Magnesium Concentration

MAGNESIUM IS SECOND only to potassium in concentration within the cell. Deficiency leads to hyperirritability of neuromuscular activity and an excess may cause a flaccid paralysis. Strange psychoses may accompany these derangements. Already, deficiency has been shown to play a part in the symptomatology of delirium tremens. Surgeon and internist alike must be alert to the possibility of its role in artificially fed patients who over a long period of time received an inadequate supply of magnesium. Also a calcium resistant tetany may develop from magnesium deficiency in hypoparathyroid subjects. In fact, calcium loading in such subjects may aggravate the magnesium deficiency. Cation losing nephropathies may be associated with deficiency, whereas anuria or severe oliguria may lead to magnesium intoxication, particularly in magnesium is administered to control convulsions or hyperkinetic states.

Personal Communication: A. J. Merrill, M. D.

Isolated Ileal Loop

AN ISOLATED ILEAL LOOP can be attached to the urinary bladder to permit enlargement of the bladder capacity. In tuberculous cystitis, interstitial cystitis (Hunner's ulcer), and in other conditions in which the bladder capacity is irreparably reduced, the authors' technique of "Cup-Patch" technique has proved satisfactory. The neurogenic bladder may be made to function in a more normal fashion as a result of the procedure.

Goodwin, Willard E., M.D.; Winter, Chester C.; and Barker, Wiley F., M.D.: "Cut-Patch" Technique of Ileocystoplasty for Bladder Neck Enlargement or Partial Substitution, Surg.-Gyn. & Obs., Vol. 108, No. 2 (February 1959).

The Gamma Globulins and Their Clinical Significance

THE AUTHORS HAVE PRESENTED a classic description of the chemistry, immunology and metabolism of gamma globulins as well as an erudite discussion of hypogammaglobulinemia and the therapeutic uses of gamma globulins. It would be well worthwhile for the readers of the Journal to obtain the fourth part of this series of articles because of its importance in the use of gamma globulins clinically. In such conditions as eczema vaccinatum where the mortality is 30 to 40 per cent, the use of hyperimmune gamma globulin is indeed encouraging. Gamma globulin prophylaxis apparently has a modifying effect on the paralytic complications of clinical poliomyelitic infections if given during the first five to seven days of the incubation period of 10 to 12 days. In addition to the various viral infections in which gamma globulin is useful there is sufficient evidence to justify the claim that gamma globulins are effective against a host of bacterial infection especially when used in conjunction with various antibiotics, a synergistic action can be expected.

Gross, P. A. M. and Janeway, C. A.: The Gamma Globulins and Their Clinical Significance, The New Eng. J. of Med., Vol. 260, No. I, II, III, and IV (January) 1959.

Penicillin in Rheumatic Fever

IN A CONTROLLED STUDY of 17 patients with acute rheumatic fever, six weeks of intensive penicillin treatment appeared to have no effect upon the acute clinical, laboratory and electrocardiographic manifestations, but did appear to produce a reduction of probable statistical significance in the incidents of valvular heart disease a year later.

Mortimer, E. A., Jr.: N. E. J. Med., 260:101, 1959.

Post Gastrectomy Syndrome, Surgical Correction

IN A DISCUSSION of the management of post gastrectomy syndrome the author recommends, when feasible: (1) a conversion of a Billroth type two to a Billroth type one, or (2) narrowing the stoma of a Billroth type one by a plastic procedure, or (3) in total or radical subtotal gastrectomies where a dumping syndrome exists the use of an inter-position procedure wherein a pouch is formed after plication of three small loops of jejunum and reanastomosis of the gastric remnant with this pouch. Where feasible, these procedures have been applied in patients with a post gastrectomy dumping syndrome and have proved to be of practical value.

Woodward, Edward, M.D.: Post Gastrectomy Syndrome, Surgical Correction, Sectional Meeting of the Amer. College of Surg., Charleston, S. C. (January) 1959.



ANEMIA AND THE HEART

George R. Dillinger, M.D., *Thomasville*

THE PATIENT PRESENTS the typical picture of heart failure. He complains of shortness of breath on slight exertion, swelling of feet and ankles, and palpitation. These symptoms may have been present for many weeks or months.

On examination there is pulsation of the neck veins; there is a palpable thrill over the cardiac area; the PMI is at the axillary line in the 5th interspace; there is a grade II systolic murmur and soft diastolic murmur at the apex. Crackling rales are present in both bases. The liver is down 5 cm below the costal margin and marked edema of the legs is present. X-ray of the chest shows a generally enlarged heart with marked increase in the size of the left ventricle. The ECG has inversion of the T waves, some depression of the ST segments, low voltage of the QRS, and a prolonged PR interval.

What kind of heart disease is present? The above picture may be presented in a patient with *no* organic heart disease. Anemia alone may present all of the above findings.

Anemia has long been known to cause the typical signs of heart failure. Also, coronary insufficiency or the anginal syndrome may be precipitated by anemia in the absence of coronary disease.

The most common cardiac abnormality in anemia is the presence of murmurs. Usually the murmur is at the apex and is systolic in time, but pulmonic and aortic murmurs are occasionally heard, and infrequently a diastolic murmur is present. The murmur as a rule is not widely transmitted, but may be indistinguishable from those of organic heart disease. In addition to murmurs, a venous thrill and hum may be present over the neck vessels.

As a rule serious heart and circulatory disturbances do not occur until the hemoglobin falls below 7 gms. per 100 cc., but they may occur with 9 gms.

or less. Usually serious manifestations appear only in long-standing anemia, whatever the cause. Pernicious anemia, hookworm, sickle cell anemia, chronic hemorrhage, malignancy, etc., may present the same circulatory picture.

In severe anemia, serious cardiac dilatation may occur with functional dilatation of the mitral and tricuspid valves, and rarely the aortic valve. The circulatory rate is usually increased. There is a decrease in the arm to tongue circulation time. The pulse pressure is elevated. The stroke volume, minute volume, cardiac rate, output, and oxygen consumption are increased. Increased cardiac output with congestive failure is present in at least four important clinical conditions: anemia, thyrotoxicosis, arteriovenous fistula and beriberi.

The cardiac dilatation and hypertrophy of long standing anemia results in fatty degeneration and flaccid heart muscle. Often the fatty degeneration produces the streaked appearance known as "tiger-ing of the heart." Areas of necrosis may occur.

The treatment of heart failure and other circulatory disturbances due to anemia is treatment of the anemia and the underlying cause. When the blood is brought back to normal levels, the failure soon clears up. The murmurs disappear, the tachycardia is relieved, and within a few days or weeks the enlarged heart returns to normal size. Other manifestations of failure are also relieved.

The digitalis preparations and other drugs used in the management of organic heart disease have little or no beneficial effect. Blood transfusions, given slowly to prevent pulmonary edema, may be life-saving, and may correct the failure, until adequate antianemic therapy can be instituted. Surgical treatment of the condition causing chronic hemorrhage may be necessary for cure.

Continued on page 122

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Chronic anemia is often the precipitating factor in circulatory disturbances when underlying organic heart disease is already present. Severe angina may develop when the patient with atherosclerotic coronary arteries becomes anemic. A bleeding ulcer,

hiatus hernia, or hemorrhoids, or any other cause or hemorrhage may precipitate the condition. On proper treatment of the anemia, the anginal syndrome may completely disappear and the patient return to normal living. Also the anemic patient with underlying rheumatic or arteriosclerotic heart disease may return to useful living by the correction of his anemia.

1959 CALENDAR OF MEETINGS

State

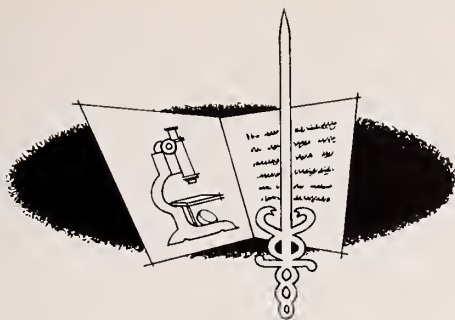
- April 6-7—Augusta Graduate Assembly, Augusta.
- April 11-12—Atlanta Society of Pathologists, Atlanta.
- May 17-20—Medical Association of Georgia, Augusta.
- May 17—Georgia Pediatric Society, Augusta.
- May 17—Georgia Psychiatric Association, Augusta.
- May 17—Georgia Dermatology Society, Augusta.
- May 17—Georgia Society of Anesthesiology, Augusta.
- May 17—Georgia Society of Ophthalmology and Otolaryngology, Augusta.
- May 17—Georgia Orthopedic Society, Augusta.
- May 17-18—Georgia Radiological Society, Augusta.
- May 18—Georgia Chapter, American College of Chest Physicians, Augusta.
- May 18—Georgia Urological Society, Augusta.
- May 19—Georgia OB-GYN Society, Augusta.
- May 19—Georgia Diabetes Association, Augusta.
- May 19—Georgia Academy of General Practice, Augusta.
- May 19—Georgia Chapter, American College of Surgeons, Augusta.
- May 19—Georgia Association of Pathologists, Augusta.
- Sept. 11-12—Georgia Heart Association, Savannah.
- Sept. 18-19—Georgia Tuberculosis Association, Athens.
- Sept. 18-19—Georgia Trudeau Society, Athens.
- Sept. 20—Georgia Psychiatric Association.
- Sept. 24-26—Georgia Chapter, American College of Surgeons, Sea Island.

Regional

- Sept. 28-29—Tennessee Valley Medical Assembly, Chattanooga, Tenn.
- Nov. 16-19—Southern Medical Association, Atlanta.

National

- April 2-4—Association of American Physicians and Surgeons, Ft. Worth, Texas.
- April 6-9—American Academy of General Practice, San Francisco, Calif.
- April 13-15—American Academy of Pediatrics, San Francisco, Calif.
- April 19—American Society of Internal Medicine, Chicago, Ill.
- April 20-24—American College of Physicians, Chicago, Ill.
- May 25-29—American College of Cardiology, Philadelphia, Penn.
- May 25-29—National Tuberculosis Association, Chicago, Ill.
- May 25-29—American Trudeau Society, Chicago, Ill.
- June 3-7—American College of Chest Physicians, Atlantic City, N. J.
- June 8-12—American Medical Association, Atlantic City, N. J.
- Aug. 30—American Congress of Physical Medicine and Rehabilitation, Minneapolis, Minn.
- Sept. 27 - Oct. 2—American College of Surgeons, Atlantic City, N. J.
- Sept. 14-17—International College of Surgeons, Chicago, Ill.
- Oct. 3-8—American Academy of Pediatrics, Chicago, Ill.
- Oct. 23-25—American Heart Association, Philadelphia, Penn.



cancer page

EARLY PROSTATIC CARCINOMA

Charles Eberhart, M.D. and Jimmie Morgan, M.D., *Atlanta*

PROGRESS MADE in the detection of early breast and cervical cancer in females encourages us to call attention to the fact that carcinoma of the prostate can also be detected at an early stage. A cancer may remain confined within the prostatic capsule for months or years, no one really knows, but if found at this time and removed, it can be cured. At a recent meeting of the Atlanta Urological Society, a poll of the urologists present showed that only eight radical prostatectomies were done in our hospitals during 1958. It is obvious that an early detection campaign is needed for these cancers. Such a campaign might well be instigated by urging all physicians of susceptible age to have their prostates examined on their birth dates.

All physicians look forward to the day when a more adequate therapy for these cancers becomes available, but in the meanwhile, the hard facts as related below should be borne in mind and acted upon.

Autopsy studies reveal frank carcinoma in the prostates of 14 per cent of males 50 years of age or older. When its incidence is classed according to decades a gradual increase in the occurrence rate is apparent as the age advances. With the increase in longevity of our population, it is inevitable that the death rate from this disease will increase. It is the cause of death in over 15 per cent of males dying of all types of malignancies being surpassed in frequency only by carcinoma of the stomach and lung. This trend will not be reversed unless physicians suspect the disease and search for early lesions which are amenable to radical prostatectomy.

Early prostatic carcinoma produces no symptoms which might suggest needed examination to the victim. The discovery of an early lesion depends en-

tirely upon finding a stony hard nodule in the prostate gland during rectal palpation. Thus, it becomes evident that discovery of curable lesions depends upon screening prostatic examinations of all men over 50 years of age. Some years ago the armed services began requiring rectal examination of all males over 40 years of age in conjunction with an annual physical examination. Of the 136 cases of prostatic carcinoma discovered, 54 per cent were considered early enough to be candidates for surgery. This is in sharp contrast to the fact that presently only about five per cent of carcinomas are amenable to surgery at the time of diagnosis.

It should be emphasized that the finding of a hard nodule in the prostate should only cause one to suspect an early carcinoma. An unquestionable diagnosis can be made only after surgical exposure of the nodule and microscopic study of it. It has been shown that a diagnosis based on rectal palpation alone is subject to a slightly more than 50 per cent error.

When an early prostatic carcinoma is found in a man whose estimated life expectancy is greater than five years, radical prostatectomy offers a superior survival rate to that which can be expected from estrogen therapy.

The discovery of early prostatic carcinoma, curable by radical surgery, lies in the hands of those physicians who are willing to search for it. Ideally all men 50 years of age or older should have annual physical examinations and routine palpation of the prostate gland should be done. The duty of discovery falls heavily upon general practitioners, internists and surgeons. All men who have had prostatic operations for benign hypertrophy should continue to have annual examination of the prostate.

VOLUNTARY HEALTH INSURANCE

OF AN ESTIMATED 15 million Americans 65 and over, Health Information Foundation reports, 39 per cent now carry some form of voluntary health insurance. The aged population is expected to reach 25 million by 1980.

The proportion of persons 65 and over with some form of voluntary health insurance increased by about half from 1952 to 1957, according to Health Information Foundation. In 1952 only 26 per cent of the aged were insured against the costs of hospital and/or medical expenses; by 1957 the proportion had risen to almost 39 per cent.

About three fifths of the aged population (65

and over) in this country are not insured against hospital and/or medical expenses. Among the uninsured, Health Information Foundation states, more than one-fourth have never tried to buy health insurance, and almost as many say they don't want it. Thirty-four per cent of the uninsured say they can't afford it, while 16 per cent say they do not believe they are eligible for it.

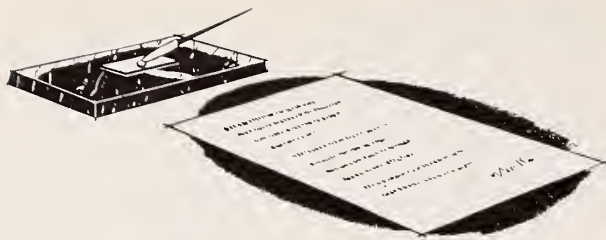
Thirty-nine per cent of the persons 65 and over in this country now have some type of voluntary health insurance. Of these, at least 93 per cent have hospitalization insurance, while 67 per cent are protected against in-hospital doctor bills and 21 per cent against physicians' charges outside the hospital.

NEW MEMBERS OF THE MAG

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Adams, Anita C.	1293 Peachtree St., N.E. Atlanta 9	DE 2	Fulton
Adams, Charles P.	1087 N. Hills Drive Decatur	DE 2	Fulton
Baird, Litell S.	80 Butler Street, S.E. Atlanta 3	DE 2	Fulton
Bloodworth, Charles H., Jr.	80 Butler Street, S.E. Atlanta 3	DE 2	Fulton
Campbell, Clarence G., Jr.	Laurens County Hospital Dublin	Active	Laurens
Carpenter, Frederick A.	Emory Univ. School of Medicine Atlanta 3	Active	Fulton
Dickinson, Thomas C.	Emory University Hospital Atlanta 22	DE 2	Fulton
Dudley, James C., Jr.	Medical Arts Center Toccoa	Active	Stephens
Haddock, Samuel T.	80 Butler Street, S.E. Atlanta 3	DE 2	Fulton
Hixson, Gordon L.	Hutcheson Memorial Hospital Ft. Oglethorpe,	Active	Walker-Catoosa- Dade
Holland, Bernard C.	Emory University Hospital Atlanta 22	Service	Fulton

NEW MEMBERS OF THE MAG *Continued*

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Hoyt, Sara L.	Mount Berry	Active	Floyd
Huenergardt, Howard D.	72 Main Street Ellijay	Active	Blue Ridge
Johnson, McLaren, Jr.	1542 Farnell Court Decatur	DE 2	Fulton
Jordan, Wm. Daniel	36 Butler Street, S.E. Atlanta 3	DE 2	Fulton
McDougall, Wm. L.	567 Orme Circle, N.E. Atlanta 6	DE 2	Fulton
Mitchell, Wm. C.	36 Butler Street, S.E. Atlanta 3	DE 2	Fulton
Moore, Milton B., Jr.	Edison Hospital Edison	Active	Southwest Georgia
Patterson, Wm. C.	Cherokee Medical Bldg. Smyrna	Active	Cobb
Pence, Robert L.	225 N. Broad Street Metter	Active	Bulloch-Candler- Evans
Peskin, Herman	1134 Druid Park Avenue Augusta	Active	Richmond
Pratt, Daniel W.	Emory University Atlanta 22	Active	Fulton
Rand, Edgar O.	1968 Peachtree Rd., N.W. Atlanta 9	DE 2	Fulton
Rape, Wm. C.	80 Butler Street, S.E. Atlanta 3	DE 2	Fulton
Reish, Martin L.	80 Butler Street, S.E. Atlanta 3	DE 2	Fulton
Rist, Karl H.	829 Bankhead Avenue, N.W. Atlanta	Active	Fulton
Rogers, Charles G.	122 Cherry Street Rockmart	Active	Polk
Saade, John E.	80 Butler Street, N.E. Atlanta 3	DE 2	Fulton
Scoggins, Robert B.	80 Butler Street, N.E. Atlanta 3	DE 2	Fulton
Thompson, Robert E.	Toccoa Clinic Toccoa	Active	Stephens
Wetherby, David	Fort Gaines	Active	Southwest Georgia
Woodbury, Philip S.	Wilcox Co. Doctor's Bldg. Rochelle	Active	Flint



abstracts by georgia authors

Skobba, Joseph S., M.D., 490 Peachtree Street, Atlanta, Georgia, "Military Psychiatry," Am. J. Psychiatry 115:649-650 (Jan) 59.

A review of the literature on Military Psychiatry during 1958 included the following developments. The development of a therapeutic program for psychosomatic patients by indoctrinating members of the medical staff in the emotions and psychosomatic manifestations, with emphasis on an emotional versus intellectual atmosphere. The psychiatrist did not see the patients but met with the medical staff at which time the emotional material developed was discussed. A clinical method of establishing the genuineness of amnesia was described. Hypnosis as a method of treatment of various psychiatric conditions developing in the military service was detailed and was proposed as a method for dealing with mass hysteria in case of nuclear warfare. In aviation medicine, the relationship of disturbed personality patterns to intolerance to G forces was investigated. The importance of the psychogenic factor in G stress was pointed out. Air sickness was found related to emotional G. By hyperventilating dogs with 100 per cent oxygen, paradoxical tissue anoxia was produced by decreasing the dissociation of oxygen from the hemoglobin. Several stages in the development of emotional breakdown were delineated and preventative measures at each step were described. The concept of man as an irresponsible automaton held during World War II was discussed and a different concept of man as a creature with intellect and free will was proposed as a basis for effective military psychiatry.

Thomas, W. C., M.D., 1616 Reynolds Street, Brunswick, Georgia, "New Corneoscleral Suturing Forceps," Arch. Ophthalmol. 60:1109 (Dec) 58.

This instrument is a $4\frac{1}{2}$ inch thumb forceps altered to adapt it for suturing penetrating wounds of the eyeball. One blade has a smooth plane surface except for a step 3 mm. from the rounded end. The other blade has two tines 10 mm. long, 0.5 mm. wide at the ends with 1.5 mm. space between them.

Following is the method of putting in the usual double-armed suture: With the margin of the wound in the forceps, the lip against the step in lower blade, the needle point is passed between the base of the tines along the surface to enter the centre of the coaptation surface at the step, and out through the

surface of the cornea. The other needle is put into the opposing side in the same manner. The single armed suture may be used with ease by starting the needle in the corneal surface between the ends of the tines, and passing it through the edge of the lip above the step. If the needle point strikes the step, it must be partly withdrawn and redirected to come out just above the step.

The Liegard suture, which I believe has a definite place in ophthalmic surgery, can easily be put in after incision by passing the needle under one or both tines without penetrating the entire thickness of the cornea. The longer bite under both tines is usually advisable, but somewhat greater care must be used to avoid a full thickness penetration.

Owen, John A., Jr., M.D., (with the technical assistance of James L. Poland, BS), Medical College of Georgia, Augusta, Georgia, "Carbohydrate Tolerance of Tube-fed Rats," Diabetes 8:51-56 (Jan-Feb) 59.

Adult rats nourished by high-carbohydrate tube-feedings were injected for four days with saline, insulin, 0.1 u/100 gm., growth hormone, 1.5 mg./100 gm., and carbutamide, 5.0 mg./100 gm., singly and in every possible combination. Effects on post-prandial blood sugar, nitrogen balance, and weight gain were compared with pre-treatment values. Results were analyzed using a factorial design and analysis of variance.

Insulin alone produced a barely significant hypoglycemia; carbutamide alone produced a more striking hypoglycemia, growth hormone alone produced significant hypoglycemia, nitrogen retention and weight gain. In every case the result of a combination of these agents was essentially the algebraic sum of their individual effects. Therefore, there was no evidence that any combination produced a synergistic or competitive effect on any of the parameters studied.

The most impressive finding is that carbutamide can produce respectable hypoglycemia in animals whose insulin-secreting mechanism must be already under some strain from the combined effects of growth hormone and a high-carbohydrate load. If this hypoglycemia is due to pancreatic insulin release, the sulfonylureas presumably must be more effective beta-cell stimulators than concurrent hyperglycemia and growth hormone excess. This postulate agrees well with clinical experi-

ence, but its biochemical explanation is still unknown.

Smith, Robert Hudson, M.D., Medical College of Georgia, Augusta, Georgia, "Normal Blood Volumes in Men and Women Over Sixty Years of Age as Determined by a Modified Cr₅₁ Method," Anesthesiology 19:752-756 (Nov-Dec) 58.

Ninety-seven healthy persons, 52 males and 45 females, ages 65-85, without systemic disease manifestations other than arteriosclerosis, eating three meals per day and working eight hours per day, were located. Blood volumes were done using a radioactive chromate dilution technique.

Males averaged 65.3 cc. Blood/Kilo.

Females averaged 56.0 cc. Blood/Kilo.

These were found to be very near to comparable study results on persons of younger ages.

The technique of Cr₅₁ blood volume determination was described minutely.

Keller, A. Paul, Jr., M.D., 1010 Prince Avenue, Athens, Georgia, "A Study of the Relationship of Air Pressure to Myringorupture," Laryngoscope 68:2015-2029 (Dec) 58.

A study was made in an effort to determine the amount of air pressure applied to the tympanic membrane necessary to cause rupture. Tests were carried out on recently deceased human eardrums and an average rupture pressure obtained. Because of the current great interest in sonic trauma these air pressure levels were converted to decibel readings to suggest possible levels of tympanic rupture from sonic trauma.

Gay, Brit B., Jr., M.D.; Sam A. Wilkins, Jr., M.D.; and Edward P. Engels, M.D., Emory Hospital, Atlanta, Georgia, "The Roentgenologic Characteristics of Chondroma of the Larynx," Am. J. Roentgenol. 80:987-996 (Dec) 58.

Chondromas of the larynx are rare tumors but present rather distinctive characteristics roentgenographically. One hundred and eighteen cases have been found listed in the literature. To this number the authors add three cases involving the subglottic space.

Chondromas of the larynx most often arise from the cricoid cartilage and usually present as a subglottic mass which is posteriorly placed, bulging into the laryngeal airway. Most of these tumors will contain considerable calcium deposits. They are usually smoothly outlined. Those tumors arising from the thyroid cartilage will deform one

side of the larynx with obliteration of the pyriform sinus and deformity of the aryepiglottic fold of the same side.

Treatment is always surgical.

McDonald, Harold P.; Wilborn E. Upchurch; and Manuel Artime, 272 Ivy Street, N.E., Atlanta 3, Georgia, "Bladder Dysfunction in Children Caused by Interstitial Cystitis," *J. Urol.* 80:354-356 (Nov) 58.

Complete examination of 368 children over a 15-year period in whom bladder dysfunction was the primary complaint is the basis of this report on interstitial cystitis in children. Symptoms directly related to the urinary tract were: frequency with or without dysuria, urgency, enuresis, dribbling of urine, nocturia, diurnal enuresis, slow stream and retention of urine.

Examination on each patient included cysto-urethroscopic examination with a foroblique instrument and retrograde pyelography. The girls out numbered boys 277 to 91 or about three to one. In 45 patients the bladder capacity under anesthesia was 150cc. or less. Over-distention by injection of an additional 30 to 60cc. caused the return fluid to be bloody. Inspection of the bladder then revealed typical areas of submucosal hemorrhage with small areas of mucosal rupture typical of Hunner ulcer or interstitial cystitis.

Treatment by distention of the bladder, fulguration of the involved areas has been helpful in relieving the symptoms of great urgency and frequency.

The response to treatment has varied rather widely but generally has been related to the ease or difficulty of obtaining increase in the bladder capacity. Treatments in some patients have extended over a period of two to three years and one patient now considered well has been under treatment since 1949.

It is urged that all children with serious bladder dysfunction be studied carefully and that interstitial cystitis be ruled out. It is concluded that interstitial cystitis has been overlooked in many children who have bladder symptoms.

Scarpa-Smith, Clorinda, M.D.; Thornton, Nancy, M.D.; Caffery, E. L., M.D.; and Greenblatt, Robert B., M.D., Medical College of Georgia, Augusta, Georgia, "Virilizing Adrenal Tumors in Children," *J. Dis. Children* 97:78-86 (Jan) 59.

Two cases of virilizing adrenal tumors in a 3½ year old colored child and a two year old Oriental child are presented. In the first case the presence of pubic and axillary hair, hypertrophy of the clitoris, and large tumor masses in the upper abdomen made the presumptive diagnosis of virilizing adrenal tumor relatively easy. Confirmatory laboratory findings included a markedly advanced bone age, grossly elevated urinary 17-ketosteroid and pregnandiol-complex excretion, and a strongly positive Allen color reaction for dehydroepiandrosterone. Surgical exploration

resulted in removal of a large neoplasm of the left adrenal. The patient did well for a few months with laboratory values returning toward normal only to rise again heralding a recurrence with pulmonary metastases followed by a rapid downhill course and death. In the second case, pubic and axillary hair growth with enlargement of the clitoris had been noted for two months. No tumors could be palpated. Laboratory findings included a slightly advanced bone age, moderately elevated 17-ketosteroid excretion, and a positive Allen test. After an unsuccessful attempt at suppression with hydrocortisone, surgical exploration was carried out with the removal of a small adenoma of the right adrenal. Following operation laboratory values returned to normal. The differential diagnosis in virilization of children lies between Cushing's disease, idiopathic constitutional hirsutism, female pseudohermaphroditism with or without adrenal hyperplasia, arrhenoblastoma, and adrenal tumor-benign or malignant. In the cases presented here, the absence of other stigmata of Cushing's precluded this diagnosis. An enlarged clitoris is seldom seen in idiopathic hirsutism, and arrhenoblastomas usually occur at a later age. The elevated steroid values of adrenal hyperplasia are usually suppressed by hydrocortisone. Failure of glucocorticoid suppression leads to the diagnosis of adrenal tumor after these other causes of virilization have been excluded.

NEW OFFICERS FOR PHYSICIANS SERVICE, INC.

H. HILT HAMMETT, JR. of LaGrange was elected president of Physicians Service, Inc. at a board of directors meeting held recently.

Dr. Hammett succeeds Luther H. Wolff of Columbus as president. Dr. Wolff will be vice president for the coming year.

Physicians Service, Inc. is the Blue Shield Plan with headquarters in Columbus which serves 122 counties in Georgia.

Other officers elected were George D. Schuessler, Columbus, secretary, and J. Mark Mote, Columbus, treasurer.

Elected to the executive committee for 1959 were Dr. Hammett, Dr. Wolff, and Dr. Schuessler.

Financial and statistical reports were presented for last year.

It was pointed out that assets of the corporation had increased from \$587,765.51 to \$621,532.80. Enrollment in the plan is now in excess of 135,800

participants. During 1958, the plan paid for its subscribers more than 30,000 doctor bills, covering physicians' services valued in excess of \$1,333,500.00.

Dr. Wolff announced that at the annual meeting of Blue Shield members the following persons had been elected to the board:

Elected for three-year terms were Sylvester Cain, Norcross; Harry Faulkner, Covington; Frank P. Holder, Jr. Eastman; Joseph B. Mercer, Brunswick; F. A. Smith, Jr., McRae; and John P. Tucker, Moultrie.

Elected for two-year terms were Lindsay Frank Lovett, Statesboro, and Charles B. Watkins, Ellijay.

Elected for a one-year term was William G. Love, Jr., Columbus.

Re-elected for three-year terms were 18 members of the board.



physician's bookshelf

BOOKS RECEIVED

Lewis, George M., M.D., F.A.C.P., **PRACTICAL DERMATOLOGY**, W. B. Saunders Company, Philadelphia, Pa., 1959, 363 pp.

Prior, John A., M.D., and Silberstein, Jack S., M.D., **PHYSICAL DIAGNOSIS**, The C. V. Mosby Company, St. Louis, Mo., 1959, 388 pp., \$7.50.

De Palma, Anthony F., M.D., **MANAGEMENT OF FRACTURES AND DISLOCATIONS**, W. B. Saunders Company, Philadelphia, Pa., 1959, 960 pp., 2 vols.

De Takats, Geza, M.D., M.S., F.A.C.S., **VASCULAR SURGERY**, W. B. Saunders Company, Philadelphia, Pa., 1959, 726 pp.

Wohl, Michael G., M.D., F.A.C.P., **LONG-TERM ILLNESS, MANAGEMENT OF THE CHRONICALLY ILL PATIENT**, W. B. Saunders Company, Philadelphia, Pa., 1959, 748 pp.

COMMUNICABLE DISEASES, published under the supervision of the Medical Department, United States Army, U. S. Government Printing Office, Washington, D. C., 1958, 544 pp., \$5.50.

Burwell, C. Sidney, M.D., and Metcalfe, James, M.D., **HEART DISEASE AND PREGNANCY**, Little, Brown and Company, Boston, Mass., 1958, 338 pp., \$10.00.

Trawell, H. C., O.B.E., M.D., F.R.C.P., and Jelliffe, D.B., M.D., M.R.C.P., D.C.H., D.T.M. & H., **DISEASES OF CHILDREN IN THE SUBTROPICS AND TROPICS**, Williams and Wilkins Company, Baltimore, Md., 1958, 919 pp.

Wolstenhalme, G. E. W., O.B.E., M.A., M.B., B.Ch., and O'Connor, Cecilia M., B.Sc., **AMINO ACIDS AND PEPTIDES WITH ANTI-METABOLIC ACTIVITY**, Little, Brown, and Company, Boston, Mass., 1958, 286 pp., \$8.75.

Rabinsan, J. F., M.B., Ch.B., **HAVING A BABY**, Williams and Wilkins Company, Baltimore, Md., exclusive U. S. agents, 1958, 100 pp., \$2.50.

REVIEWS

Walstenhalme, C. E. W., O.B.E., M.A., M.B., B.Ch., and O'Connor, Cecilia M., B.Sc., **CIBA FOUNDATION SYMPOSIUM—NEUROLOGICAL BASIS OF BEHAVIOUR**, Little, Brown, & Company, Boston, 1958, 400 pp., \$9.00.

THIS BOOK IS ANOTHER MILESTONE in the series of Ciba Foundation Symposia. Its contents are a detailed report of papers presented at the meeting of an international congress of neurological sciences held in London in the summer of 1957. This symposium was timed to commemorate the centenary of the birth of the pioneer neurophysiologist Sherrington.

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

The subject matter consists of 19 papers on research projects ranging from microphysiology of neurones to phenomena of behaviour and psychology. They are presented by such outstanding men as Jasper and Penfield of Montreal; Bard of Baltimore; R. Brain, Sherwood, and Jefferson of England; Eccles of Australia, just to name a few. Each paper contains a number of illustrations and pictures and is followed by a lively discussion period. This volume gives quite a few significant conclusions bound to influence the future of neurology and psychiatry and related fields.

George P. Dillard, M.D.

Cowdry, E. V., Ph.D., Sc.D., (Hon.) (Editor) **THE CARE OF THE GERIATRIC PATIENT**, The C. V. Mosby Co., St. Louis, 1958, 438 pp., \$8.00.

EXCEPT FOR THE FIELDS OF PEDIATRICS and obstetrics, the physician and surgeon dealing with patients is daily faced with medical problems of the elderly segment of our population. There is evidence that the percentage of people over the age of 65 in the United States will increase for some years before it levels off.

This volume, edited by Dr. E. V. Cowdry, represents the combined work of 22 contributors. The material of a symposium on aging of the Los Angeles County Medical Association forms the basis of the book and was expanded by additional chapters. One of the greatest virtues of this book is its broad approach to the problem of aging. There are separate chapters on many facets of geriatric care such as medical, surgical, psychological, and anasthetical problems. Nutrition, drugs, and genetic factors are discussed. Since a geriatrician cannot properly treat his patients without consideration of the non-medical phases of aging, the text contains much material on gerontology, including biologic, economic, and social aspects of aging. Nursing care, hospitalization and rehabilitation receive attention.

Because this book lists all the organizations and services that are available for older people, it should be useful as a reference for physicians who are interested in the total approach to the care of the aging patient. In fact, there are many aspects of medicine in which the total approach achieved in this volume could well be covered in a single text.

Harry H. Brill, M.D.

Sakel, Manfred, M.D., **EPILEPSY**, Philosophical Library, New York, N. Y., 1958, 204 pp., \$5.00.

THIS BOOK, WRITTEN BY THE DISCOVERER of insulin shock treatment of mental illness, is a reflection of Dr. Sakel's interest in epilepsy. Though the manuscript for "Epilepsy" was uncompleted at the time of the author's

death, his friends published it as a tribute to the memory of Dr. Sakel. As such, this book fills its purpose. However, the book contributes little toward presenting a clear scientific analysis of the pathophysiologic mechanisms of cerebral seizures, nor is its discussion of diagnosis and treatment particularly helpful.

Perhaps Dr. Sakel had originally intended this book to be a forum for the presentation of his ideas regarding the pathophysiology of seizures. Based on the similarities between the clinical picture of the insulin-induced convulsion and the seizure of idiopathic epilepsy, he suggests that their basic mechanisms may be the same and that their purposes are identical. To quote the author, "Both act to preserve the hormonal, chemical, and biologic integrity of the individual by stimulation of the sympathetic nervous system." Unfortunately, Dr. Sakel presents little in the way of convincing data to support this intriguing though somewhat teleologic hypothesis.

In the light of other well-documented works on the subject, this reviewer feels that "Epilepsy" has no particular place in the library of the student or the practitioner interested in developing a clear understanding of the problems posed by the convulsive disorders.

Herbert R. Karp, M.D.

Strean, Lyon P., M.Sc., Ph.D., D.D.S., F.A.P.H.A., THE BIRTH OF NORMAL BABIES, Twayne Publishers, New York, 1958, 194 pp., \$3.95.

THE AUTHOR ATTEMPTS TO REVIEW, in simple language, some of his observations and clinical experiences concerning congenital malformations and miscarriages. He feels that there are some abnormalities of the newborn which are inherited, but that the possibility exists that the gene will be permitted to express itself in the form of a congenital defect only in the presence of severe stress in the first trimester. He recognizes three kinds of stress: (1) traumatic, (2) physiologic, and (3) emotional. He also reasons that severe stress is known to affect the adrenal glands resulting in an increased secretion of cortisone. If, during the first trimester of pregnancy when the various fetal organs and structures are being formed, this excessive output of cortisone occurs, then it can cause an abnormal intrauterine environment which would interfere with the normal development of the rudimentary cells resulting in miscarriage or deformity of the infant. He offers experimental observations, statistical data from retrospective case studies, and many case histories to support his views.

It must be admitted that this is an unusual approach to the etiology of an age-old problem. While no one can deny the author's conclusions, neither is his proof conclusive. The theory is interesting but highly speculative to say the least. It will be interesting to await the results of further observations and studies in this distressing complication of the reproduction of the race.

Carl J. Brunoehler, M.D.

Segaloff, Albert, M.D., BREAST CANCER—The Second Biennial Louisiana Cancer Conference, The C. V. Mosby Co., St. Louis (October) 1958, 257 pp., \$5.00.

THIS COMPILATION OF PAPERS presented to the Louisiana Cancer Conference covers the subject from Basic Biology to definitive treatment in all of its phases. Although the statistical studies of Haagensen, McWhirter, and others are interesting and the controversy developed over treatment stimulating the new thinking presented both as to etiology and treatment by 30 leaders in their

respective fields makes this work worth reading.

There is a long panel discussion at the end of each of the sections dealing with (1) Basic Biology I, (2) Definitive Treatment, (3) Basic Biology II, and (4) Hormonal Therapy.

Certainly no field of cancer effort is more confused than that dealing with the breast and its relations. The unrestrained discussions in the panels given as opposing views by recognized authorities is likely to keep the breast surgeon's thinking fluid and cause some solid dictums to seem obsolete.

William E. Mitchell, M.D.

Roberts, H. J., M.D., DIFFICULT DIAGNOSIS, W. B. Saunders Company, Philadelphia and London, 1958, 913 pp.

THE SUB-TITLE OF THIS VOLUME is "A Guide to the Interpretation of Obscure Illness." It is written by a well trained young internist who was formerly research fellow and instructor in medicine at Tufts University Medical School and also at Georgetown Medical School. He has made an effort to write a book on diagnosis on an advanced postgraduate level for the use of the practicing internist. There are at least 2,000 references to the literature and many of these to multiple sources. He has obviously spent many hours in a good medical library.

A tremendous amount of useful material is presented in a very brief and straightforward fashion. The bulk of the references are to very recent literature. The author has also quite obviously had personal experience with most of the entities about which he writes.

In Part I he has organized the material in such a way as to group related diseases which frequently produce puzzling illness. Part II is a classification and analysis of useful diagnostic procedures. The book also contains a useful index of signs, symptoms, and laboratory manifestations of diseases.

This reviewer knows of no other textbook in which such a tremendous amount of useful material can be found by the physician attempting to diagnose a puzzling disease state. The author has paid particular attention to the rare and unusual causes for various clinical syndromes. Every practicing internist should own a copy of this book but he should also have access to a good medical library in which he can look up the author's references for more extensive and complete coverage of the subjects which are briefly listed in this excellent comprehensive textbook of advanced diagnosis.

Arthur M. Knight, Jr., M.D.

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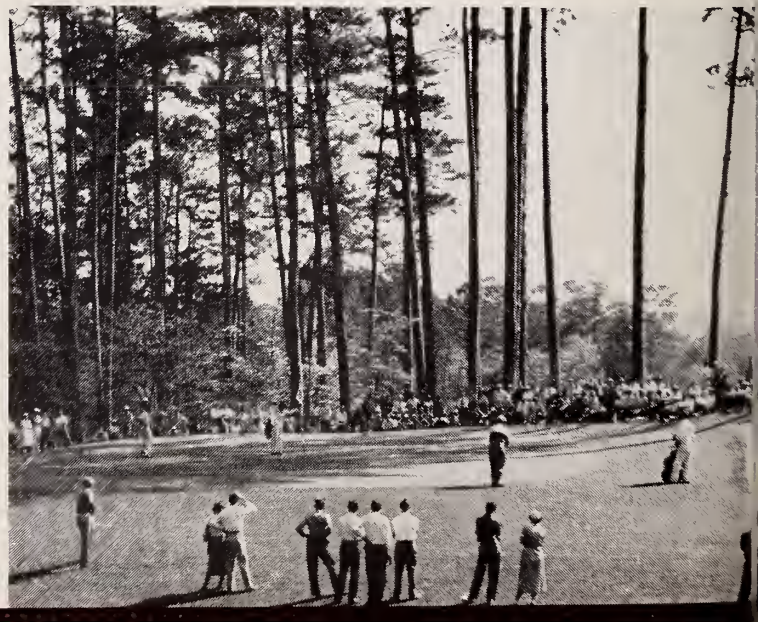


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OFFICIAL CALL

to the Officers and Members of the Medical Association of Georgia:

THE *105TH ANNUAL SESSION of the Medical Association of Georgia will be held at the Bon Air Hotel, Augusta, Georgia May 17-20, 1959.

The MAG Official Registration Desk will be located to the right of the lobby of the Bon Air Hotel just adjacent to the meeting halls and exhibit room entrance. Registration for Association Members and guests will be Sunday, May 17 from 1:00 P.M. to 5:00 P.M.; Monday, May 18 and Tuesday, May 19 from 8:00 A.M. to 5:00 P.M.

The Association House of Delegates will convene Sunday, May 17 at 5:00 P.M. in the Crystal Room, Bon Air Hotel, and will reconvene Wednesday,

May 20 at 9:00 A.M. in the Crystal Room of the Bon Air Hitel. The first MAG General Business Session will convene Monday, May 18 at 11:45 A.M. in the Crystal Room, Bon Air Hotel, and will reconvene Wednesday, May 20, at 11:30 A.M. in the Crystal Room, Bon Air Hotel.

The Scientific Section Meetings of the Annual Session will be convened in the various meeting rooms of the Bon Air Hotel beginning Sunday afternoon, May 17 at 2:00 P.M; Monday morning, May 18 at 9:00 A.M.; Monday afternoon, May 18 at 2:30 P.M; Tuesday morning, May 19 at 9:00 A.M.; and Tuesday afternoon, May 19 at 2:30 P.M. These Sections Meetings are scheduled as follows:

Sunday, May 17

- 12:00 P.M. Dermatology Section, 3201 Huxley Drive
- 2:00 P.M. Radiology, Orthopedics, and Psychiatry—Neurology—Neurosurgery Joint Section, Crystal Room
- 2:00 P.M. Pediatrics, Anesthesiology and EENT Joint Section, Press Room
- 5:00 P.M. MAG House of Delegates, Crystal Room
- 8:30 P.M. General Session (G.P. Night), Crystal Room

Monday, May 18

- 9:00 A.M. General Session (G.P. Day), Crystal Room
- 9:00 A.M. Georgia Radiological Society Business Meeting, Augusta Room
- 11:45 A.M. General Business Session, Crystal Room
- 2:30 P.M. Surgery, Industrial Surgery, Anesthesiology, Urology and Orthopedic Joint Section, Crystal Room

- 2:30 P.M. Medicine, Diabetes, Dermatology and Chest Joint Section, Press Room
- 2:30 P.M. Radiology Section, Augusta Room

Tuesday, May 19

- 9:00 A.M. Medicine, Diabetes, Dermatology and Chest Joint Section, Crystal Room
- 9:00 A.M. Surgery Section, Press Room
- 10:00 A.M. Pediatrics and General Practice Joint Section, Augusta Room
- 12:00 P.M. General Session Lectureship, Crystal Room
- 2:30 P.M. Obstetrics and Gynecology & General Practice Joint Section, Crystal Room
- 2:30 P.M. Pathology Section, Augusta Room

Wednesday, May 20

- 9:00 A.M. House of Delegates Second Session, Crystal Room
- 11:30 A.M. MAG General Business Session, Crystal Room

MAG OFFICERS

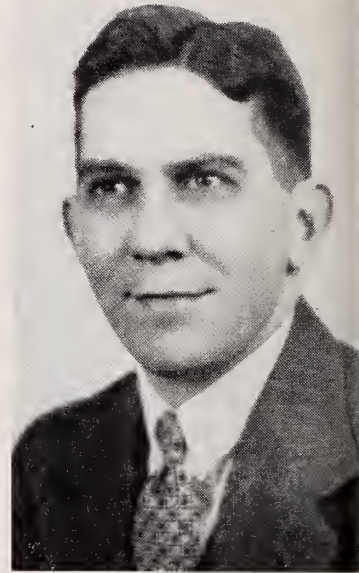
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Charles R. Andrews, Canton

Committee Reorganization

- W. G. Elliott, Cuthbert, *Chairman*
J. W. Chambers, LaGrange
Thomas W. Goodwin, Augusta

Cultists

- F. G. Eldridge, Valdosta, *Chairman*
Robert L. Brown, Emory University
Raymond F. Spanjer, Cedartown
Albert M. Deal, Statesboro

Councilor Apportionment and Redistricting

- Thomas W. Goodwin, Augusta, *Chairman*
Maurice F. Arnold, Hawkinsville
George T. Nicholson, Cornelia

Standardization of Insurance Forms

- Joseph B. Mercer, Brunswick, *Chairman*
W. L. Pomeroy, Waycross
Robert E. Shiflet, Toccoa
Charles T. Cowart, LaGrange
John B. O'Neal, Elberton

Institution-Physician Relations

- F. G. Eldridge, Valdosta, *Chairman*
Stewart D. Brown, Jr., Royston
Darrell Ayer, Atlanta
Lester Rumble, Atlanta
George Schuessler, Columbus
R. B. Martin, Cuthbert

Headquarters Building

- Chris J. McLoughlin, Atlanta, *Chairman*
Lee Howard, Sr., Savannah
George R. Dillinger, Thomasville
W. Bruce Schaefer, Toccoa
J. G. McDaniel, Atlanta
Luther Wolff, Columbus

Medical School Course

- Chris J. McLoughlin, Atlanta, *Chairman*
Rafe Banks, Gainesville
T. A. Sappington, Thomaston

Clarkesville Laboratory School

- D. Lloyd Wood, Dalton, *Chairman*
Hamil Murray, Gainesville
Lee Howard, Jr., Savannah
Robert E. Ridgway, Royston
James A. Green, Athens

Annual Session

- Henry H. Tift, Macon, *Chairman*
Peter Hydrick, College Park, *Commercial Exhibits*
Ted F. Leigh, Emory University
Scientific Exhibits and Meeting Rooms
C. Raymond Arp, Atlanta, *Banquet*
Simone Brocato, Columbus,

Unauthorized Practice of Medicine By Ancillary Personnel

- A. M. Phillips, Macon, *Chairman*
Ralph W. Fowler, Marietta
W. L. Pomeroy, Waycross

Distinguished Service Award

- David Henry Poer, Atlanta, *Chairman*
C. F. Holton, Savannah
Ralph H. Chaney, Atlanta

Lectureship

- George Alexander, Forsyth, *Chairman*
Mark S. Dougherty, Jr., Atlanta
J. W. Chambers, LaGrange

SPECIAL COMMITTEES (Appointed Annually)

American Medical Education Foundation

- George T. Nicholson, Cornelia, *Chairman*
J. Hubert Milford, Hartwell
Ruskin King, Savannah
H. Ansley Seaman, Waycross
W. E. Storey, Columbus
John Ridley, Atlanta

Blood Banks

- Lester Forbes, Atlanta, *Chairman*

- Lee Howard, Jr., Savannah
Walter L. Sheppard, Augusta
Hamil Murray, Gainesville
F. H. Thompson, Atlanta
Frank Lewis Beckel, Columbus
Joseph Hertell, Atlanta

Crippled Children

- J. C. Hughston, Columbus, *Chairman*
F. James Funk, Jr., Atlanta
John L. Chandler, Jr., Augusta
H. W. Muecke, Waycross

- Robert A. Sears, Atlanta
J. W. Bennett, Augusta
W. G. Elliott, Cuthbert
W. U. Clary, Savannah
Fred E. Murphy, Jr., Thomasville
Charles E. Irwin, Atlanta

Eyecare of the Newborn

- J. Jack Stokes, Atlanta, *Chairman*
Thomas C. McPherson, Atlanta
Joseph L. Girardeau, Atlanta
C. A. N. Rankine, Atlanta

Medical Civil Preparedness

Edgar M. Dunstan, Atlanta, *Chairman*
 Lee Battle, Rome
 Perry P. Volpito, Augusta
 J. Fletcher Hanson, Macon
 T. J. Ferrell, Waycross
 Joseph S. Skobba, Atlanta
 Charles E. Dowman, Atlanta
 George M. Hutto, Columbus
 John L. Elliott, Savannah
 Virgil B. Williams, Griffin

Ministerial Liaison

Needham B. Bateman, Atlanta, *Chairman*
 Avery M. Dimmock, Atlanta

Marion A. Hubert, Athens
 Edward Y. Walker, Milledgeville
 F. G. Eldridge, Valdosta

School Child Health

Grady Black, Griffin, *Chairman*
 Robert Neil Poole, Atlanta
 M. D. Pittard, Toccoa
 Virginia McNamara, Atlanta
 Maurice F. Arnold, Hawkinsville

Radiologic Safety

Robert M. Tankesley, Atlanta, *Chairman*
 F. G. Eldridge, Valdosta
 Enoch Callaway, LaGrange

Oliver T. Ghent, Gainesville
 R. C. Pendergrass, Americus

VFW Liaison

W. Bruce Schaefer, Toccoa, *Chairman*
 Charles R. Andrews, Canton
 Chris J. McLoughlin, Atlanta

Weekly Health Column

H. C. Derrick, Jr., LaFayette, *Chairman*
 C. J. Wyatt, Jr., Rome
 J. Harry Lange, Atlanta
 Lamar F. Glass, Atlanta
 August S. Yochem, Jr., Atlanta
 Jule C. Neal, Jr., Macon
 E. P. Inglis, Marietta

STANDING COMMITTEES

Cancer

Everett L. Bishop, Atlanta, *Chairman*
 Hoke Wammock, Augusta
 J. E. Scarborough, Emory University
 David Henry Poer, Atlanta (1960)
 R. C. Pendergrass, Americus
 Enoch Callaway, LaGrange, *ex-officio*
 Wray J. Tomlinson, Columbus
 John L. Barner, Athens
 F. G. Eldridge, Valdosta
 Lester Harbin, Rome
 Thomas Harrold, Macon
 M. Fernan Nunez, Dublin
 Robert L. Brown, Emory University
 Neal F. Yeomans, Waycross
 Julian B. Neel, Thomasville
 Major F. Fowler, Atlanta
 Wadley R. Glenn, Atlanta
 John T. Mauldin, Atlanta
 P. F. Brown, Jr., Gainesville

Crawford W. Long Memorial

Lester Rumble, Jr., Atlanta,
Chairman (1961)
 P. P. Volpito, Augusta (1960)
 A. B. Boyd, Athens (1959)

Constitution & By-Laws

Thomas W. Goodwin, Augusta
Chairman (1961)
 William P. Harbin, Rome (1959)
 Eustace A. Allen, Atlanta (1960)

Geriatrics

Harry Brill, Columbus, *Chairman* (1961)
 Edgar Woody, Jr., Atlanta (1960)
 Milton F. Bryant, Atlanta (1959)

History & Vital Statistics

Carl C. Aven, Marietta, *Chairman* (1960)
 Morgan Raiford, Atlanta (1959)
 Herbert Alden, Atlanta (1961)
 Edgar Woody, Jr., Atlanta, *ex-officio*
 R. H. McDonald, Newnan, *ex-officio*

Hospital Relations

Mildford B. Hatcher, Macon,
Chairman (1961)
 David Henry Poer, Atlanta,
Co-Chairman (1960)
 Kirk Shepard, Thomasville (1959)
 Robert B. Martin, Cuthbert (1961)
 Herbert D. Tyler, Thomaston (1960)
 H. A. Goodwin, Summerville (1959)
 James R. Paulk, Moultrie (1961)
 Rafe Banks, Gainesville (1960)
 A. W. Simpson, Jr., Washington (1959)
 Walter Brown, Savannah (1961)
 J. Miller Byne, Waynesboro (1960)
 Fred H. Simonton, Chickamauga (1959)
 W. L. Pomeroy, Waycross (1961)
 H. C. Derrick, Jr., Lafayette (1960)
 P. W. Warga, Athens (1959)

Henry H. Tift, Macon (1961)
 Frank G. Eldridge, Valdosta (1960)
 A. B. Conger, Columbus (1959)

Industrial Health

T. A. Peterson, Savannah, *Chairman* (1960)
 Joe M. Bosworth, Atlanta (1960)
 Allen M. Collinsworth, Atlanta (1959)
 Alex Jones, Griffin (1961)

Insurance & Economics

David R. Thomas, Augusta, *Chairman*
 1—John L. Elliott, Savannah (1960)
 2—Rudolph F. Bell, Thomasville (1959)
 3—Luther H. Wolff, Columbus (1961)
 4—Thomas E. Floyd, Griffin (1960)
 5—Charles S. Jones, Atlanta, *Co-Chairman*
 (1959)
 6—Herbert M. Olnick, Macon (1961)
 7—E. S. Marks, Marietta (1960)
 8—W. L. Pomeroy, Waycross (1959)
 9—W. P. Nicholson, III, Gainesville (1961)
 10—David R. Thomas, Jr., Augusta (1961)

Legislation

J. Frank Walker, Atlanta,
Chairman (1960)
 E. A. Allen, Atlanta, *Vice-Chairman* (1959)
 Albert M. Deal, Statesboro (1959)
 Virgil B. Williams, Griffin (1961)
 T. A. Peterson, Savannah (1961)

Maternal & Infant Welfare

Eugene Griffin, Atlanta, *Chairman* (1959)
 H. J. Bickerstaff, Columbus (1960)
 Helen W. Bellhouse, Atlanta (1961)
 James W. Bennett, Augusta (1960)
 Peter Hydrick, College Park (1960)
 A. G. LeRoy, Thomson (1959)
 Frank McKemie, Albany (1961)
 C. M. Mulherin, Augusta (1961)

Medical Defense

Charles S. Jones, Atlanta, *Chairman* (1961)
 W. Bruce Schaefer, Toccoa (1959)
 Henry Finch, Atlanta (1963)
 C. J. McLoughlin, Atlanta, *ex-officio*
 J. G. McDaniel, Atlanta, *ex-officio*

Medical Education

C. F. Stone, Atlanta, *Chairman* (1960)
 R. C. McGahee, Augusta (1959)
 J. C. Metts, Savannah (1961)
 Harry B. O'Rear, Augusta, *ex-officio*
 A. P. Richardson, Atlanta, *ex-officio*

Mental Health

Rives Chalmers, Atlanta, *Chairman* (1959)
 J. R. Shannon Mays, Macon (1960)
 R. J. Van de Wetering, Atlanta (1961)
 Arthur M. Knight, Jr., Waycross (1959)
 Paul T. Scoggins, Commerce (1960)

Albert J. Kelley, Savannah (1961)
 T. J. Vansant, Jr., Marietta (1959)
 Richard E. Felder, Atlanta (1960)
 H. E. Valentine, Jr., Gainesville (1961)
 T. G. Peacock, Milledgeville, *Consultant*
 Guy V. Rice, Atlanta, *Consultant*
 Trawick Stubbs, Atlanta, *Consultant*

Professional Conduct

W. F. Reavis, Waycross, *Chairman*
 C. F. Holton, Savannah
 Wm. P. Harbin, Jr., Rome
 H. Dawson Allen, Milledgeville
 W. Bruce Schaefer, Toccoa

Public Health

H. J. Bickerstaff, Columbus,
Chairman (1959)
 Walter Brown, Savannah (1960)
 J. B. Neighbors, Athens (1960)
 Alex G. Little, Valdosta (1961)
 Lee Battle, Jr., Rome (1961)
 John Venable, Atlanta, *ex-officio*

Public Service

John P. Heard, Decatur, *Chairman* (1960)
 E. P. Inglis, Marietta (1960)
 Albert M. Boozer, Dalton (1959)
 E. C. McMillan, Macon (1961)
 Peter L. Scardino, Savannah (1960)
 Dan B. Kahle, Atlanta (1961)
 Clarence C. Butler, Columbus (1959)
 Charles W. Hock, Augusta (1961)
 I. R. Berger, Athens (1959)
 Frank McKemie, Albany (1960)

Rural Health

Albert L. Morris, Fairburn, *Chairman* (1960)
 1—Kathrine Hawkins, Sylvania (1960)
 2—Carl Pittman, Jr., Tifton (1960)
 3—Charles McArthur, Cordele (1959)
 4—T. A. Sappington, Thomaston (1961)
 5—Albert L. Morris, Fairburn (1960)
 6—H. R. Cary, Milledgeville (1959)
 7—H. C. Derrick, Lafayette (1961)
 8—J. W. Yeomans, Jesup (1960)
 9—Rafe Banks, Gainesville (1961)
 10—Hugh B. Cason, Warrenton (1959)

Scientific Exhibit Awards

Ted F. Leigh, Emory University,
Chairman (1960)
 Hoke Wammock, Augusta (1959)
 Henry H. Boyter, Columbus (1961)

Veterans' Affairs

C. R. Andrews, Canton, *Chairman* (1959)
 Lee Howard, Jr., Savannah (1960)
 Hartwell Joiner, Gainesville (1961)

Woman's Auxiliary

Virgil B. Williams, Griffin, *Chairman* (1960)
 W. G. Elliott, Cuthbert (1960)
 W. Bruce Schaefer, Toccoa (1959)

STATE BOARDS — RELATED COMMITTEES

State Board of Health

Fred H. Simonton, Chickamauga, *Chairman*
J. G. Williams, D.D.S., Atlanta, *Co-Chairman*
J. M. Byne, Jr., Waynesboro
A. G. Funderburk, Moultrie
Maurice F. Arnold, Hawkinsville
Virgil Williams, Griffin
Harold McDonald, Atlanta
A. M. Phillips, Macon
A. G. Little, Jr., Valdosta
Ben K. Looper, Canton
D. N. Thompson, Elberton
J. M. Hawley, D.D.S., Columbus
J. B. Butts, Ph.G., Milledgeville
W. W. Webb, Ph.G., Leslie

Hospital Advisory Committee

(State Department of Public Health)

W. L. Pomeroy, Waycross—1959
Rafe Banks, Jr., Gainesville—1959
Milford B. Hatcher, Macon—1961
David Henry Poer, Atlanta—1959
P. W. Warga, Athens—1959
Mr. Frank W. Allcorn, Warm Springs
Thomas Conner, D.D.S., Atlanta
Mr. Terry Hiers, Jr., Americus
Mr. Oscar S. Hilliard, Fort Oglethorpe
Miss Dana Hudson, Atlanta
Mr. A. P. Jarrell, Atlanta
Mr. George E. Linney, Griffin
Mr. J. J. McLanahan, Elberton
Mr. Louis Newmark, Atlanta
T. F. Sellers, Atlanta

Hospital Care Council

Mr. Oscar S. Hilliard, Fort Oglethorpe,
Chairman
Mr. Frank W. Allcorn, Jr., Warm Springs,
Vice-Chairman
Mr. John W. Collins, Jr., Atlanta, *Secretary*
Mr. George L. Mathews, Americus
A. B. Conger, Columbus

W. Bruce Schaefer, Toccoa
Mr. Frank L. Baker, Jr., Rome
Mr. James E. Evitt, Ringgold
Mr. O. B. Hardy, Albany
Mr. E. H. Kalman, Albany
Mr. Jeff Gilreath, Cartersville
T. F. Sellers, Atlanta, *Ex-Officio*
Judge Alan Kemper, Atlanta, *Ex-Officio*

Georgia Hospital—

Medical Mediation Council

Mr. Millard L. Wear, Marietta (G.H.A.)
Mr. Whitelaw H. Hunt, Augusta (G.H.A.)
Mr. Frank W. Allcorn, Jr., Warm Springs
(Gov. Bds.)
Mr. David Hamilton, Atlanta (Gov. Bds.)
Milford B. Hatcher, Macon (MAG)
Mr. Arthur W. Smith, Macon
(Hospital Adm.)
R. C. Williams, Atlanta (Public Health)
Fred H. Simonton, Chickamauga (GAGP)
Mark S. Dougherty, Atlanta (MAG)
George M. Hutto, Columbus
(Radio.-Anes.-Path.)
John Mauldin, Atlanta (ACS)

State Board of Medical Examiners

L. W. Willis, Bainbridge, *President*,
Sept. 1, 1959
Paul Scoggins, Commerce, Sept. 1, 1961
Carl Savage, Montezuma, Sept. 1, 1959
Alex Russell, Winder, Sept. 1, 1962
J. W. Palmer, Ailey, Sept. 1, 1962
Q. A. Mulkey, Millen, Sept. 1, 1961
R. H. McDonald, Newnan, Sept. 1, 1962
Albert M. Deal, Statesboro, Sept. 1, 1959
Fred J. Coleman, Dublin, Sept. 1, 1960
Grady N. Coker, Canton, Sept. 1, 1960

State Medical Education Board

Raymond Evans, Sr., Clayton, *Chairman*,
March 31, 1961
Mr. L. R. Seibert, Atlanta, *Secretary-Treasurer*

Herman Dismuke, Ocilla, March 31, 1961
J. C. Tanner, Jr., Atlanta, March 31, 1961
W. Bruce Schaefer, Toccoa, May, 1959
Lee Howard, Sr., Savannah, May, 1960

Interprofessional Council of Georgia

W. A. Carr, D.D.S., Augusta, *Chairman*
Irwin T. Hyatt, D.D.S., Atlanta
Robert C. Powell, D.D.S., Rome
C. J. McLoughlin, Atlanta
John G. Wells, Newnan
John K. Davidson, Columbus
George Mudter, Ph.G., Manchester,
Vice-Chairman
J. V. Riley, Ph.G., Atlanta
Tyre Watson, Jr., Ph.G., Decatur

Physician-Lawyer Liaison

W. Bruce Schaefer, Toccoa
W. L. Pomeroy, Waycross
Charles S. Jones, Atlanta
Mr. Samuel E. Kelly, Columbus
Mr. Maylon B. Clinkscales, Commerce
Mr. John Dunaway, Atlanta

Talmadge Hospital Liaison

MAG—W. Bruce Schaefer, Toccoa,
Chairman
RCMS—Gordon Kelly, Augusta
A. J. Waters, Augusta
MCG—Harry B. O'Rear, Augusta
Edgar Pund, Augusta
1st—J. Miller Byne, Waynesboro
2nd—W. P. Rhyne, Albany
3rd—Henry Boyter, Columbus
4th—J. R. Turner, LaGrange
5th—Lamar Peacock, Atlanta
6th—Milford B. Hatcher, Macon
7th—Ralph Fowler, Marietta
8th—R. A. Pumpelly, Jesup
9th—A. A. Rogers, Jr., Commerce
10th—Stewart D. Brown, Royston

ANNUAL SESSION COMMITTEES

Annual Session General Chairman

C. H. Thigpen, *Chairman*

Auxiliary Liaison

L. Q. Hair, *Chairman*
W. E. Bellamy

Credentials and Registration

Charles Mulherin, *Chairman*
Ben Moss

Entertainment

Hoke Wammock, *Chairman*
Alfred Battey
Robert McKnight
S. K. Brown

Finance

W. N. Agostas, *Chairman*
Ted Everett

Golf

Joe Mulherin, *Chairman*
Steve Brown
M. H. Wylie

Hospitality

Gus Carswell, *Chairman*
Stewart Flanagin
Jack Howard
Merritt Whelchel
Robert Ellison
W. H. Moretz
Walter Sheppard
Dan Grant

William Steed

Ed Rushia
Thomas Findley
George W. Smith

Publicity

C. M. Templeton, *Chairman*
Elizabeth Thompson
F. E. Bliven
Curtis Carter
C. A. White

Transportation

Pomeroy Nichols, *Chairman*
Calhoun Witham
James Kay
Joe Green
Steve Mulherin

Specialty Society Program Chairmen

Georgia Academy of General Practice

C. M. Templeton

Georgia Industrial Surgeons

A. S. Carswell

Georgia Chapter, American College of Physicians

Harry T. Harper, Jr.

Georgia Heart Association

Louis L. Battey

Georgia State Obstetrical and Gynecological Society

John T. Persall

Georgia Orthopedic Society

A. S. Carswell

Georgia Society of Anesthesiologists

A. J. Waters

Georgia Chapter, American College of

Chest Physicians

Curtis H. Carter

Georgia Trudeau Society

C. H. Carter

Georgia Society of Dermatologists

J. Malcolm Bazemore

Georgia Diabetes Association

Nathan DeVaughn

Georgia Society of Ophthalmology and

Otolaryngology

Wm. O. White

Georgia Association of Pathologists

E. V. Hastings

Georgia Pediatric Society

W. A. Wilkes

Psychiatry-Neurology-Neurosurgery

E. J. McCranie

Georgia Radiological Society

Russell Wigh

Georgia Chapter, American College of Surgeons

Robert G. Ellison

Georgia Urological Society

Robert Rinker

Information

Registration

The Medical Association of Georgia official registration desk will be located to the right of the lobby of the Bon Air Hotel just adjacent to the meeting hall and exhibit room entrance. It will be open for registration of Association members and guests at 1 P.M., Sunday, May 17, 1959 and 8 A.M., Monday and Tuesday, May 18-19. Members and guests should register there *immediately upon arrival* to obtain badges and programs. No one will be admitted to the exhibit room and meeting hall without official badges.

Message Center and General Information

A message center will be maintained at the MAG Official Registration Desk just off the lobby in the Bon Air Hotel to receive incoming calls. Pages from the Woman's Auxiliary to the Medical Association of Georgia will staff this center during the entire session. All notices of an official nature will be posted on the official bulletin board at the message center.

Headquarters Office and Press Room

The Association staff will maintain a MAG Headquarters Office in Room 229, Bon Air Hotel. A Press Room for Association Annual Session and Auxiliary Convention publicity has been designated to Room 228, Bon Air Hotel.

House of Delegates

The MAG House of Delegates will meet Sunday afternoon, May 17 at 5 P.M. in the Crystal Room (Main meeting room) Bon Air Hotel and will reconvene Wednesday, May 20 at 9 A.M. in the Crystal Room, Bon Air Hotel. All MAG Delegates are requested to attend both of these sessions of the House of Delegates *fifteen minutes prior to the time they are convened* so that the delegates may be registered on the Official Roll.

Memorial Service

The Medical Association of Georgia will hold its Annual Memorial Service at the opening session of the House of Delegates at 5 P.M., Sunday, May 17, 1959 in the Crystal Room (Main meeting room), Bon Air Hotel. All members are cordially invited to attend. This service is held in the memory of members who have died during the past year.

George T. Banks, Fairmount, April 26, 1958
H. A. Barron, Thomaston, November 16, 1958
W. C. Blandford, Atlanta, December 2, 1958
William W. Bryan, Atlanta, April 10, 1958
J. F. Chisholm, Savannah, December 13, 1958

Virgil C. Cooke, Savannah, November 10, 1958
Hal M. Davison, Atlanta, April 26, 1958
James H. Dillard, Davisboro, November 18, 1958
Dan C. Elkin, Lancaster, Ky., November 3, 1958
M. J. Epting, Savannah, May 8, 1958
John B. Fitts, Atlanta, March 5, 1958
D. A. Forrer, Griffin, August 13, 1958
C. C. Giddens, Valdosta, February 17, 1958
Claude Griffin, Atlanta, May 8, 1958
G. T. Harper, Dewey Rose, September 29, 1958
J. E. Johnson, Jr., Elberton, October 30, 1958
O. D. King, Bremen, May 15, 1958
Morris J. Kusnitz, Jr., Alamo, September 7, 1958
R. N. Little, Summerville, December 2, 1958
I. M. Lucas, Albany, April 3, 1958
W. H. Lucas, Cedartown, March 25, 1958
J. M. McElveen, Brooklet, November 23, 1958
H. M. Michel, Augusta, May 25, 1958
J. H. Mull, Rome, September 21, 1958
Richard M. Nelson, Atlanta, February 6, 1958
Ralph G. Newton, Macon, June 5, 1958
F. O. Pearson, Macon, January 8, 1959
B. F. Riley, Jr., Thomson, November 11, 1958
C. L. Roles, Camilla, February 23, 1958
J. F. Schneider, Atlanta, February 9, 1958
W. J. Schneider, Folkston, April 19, 1958
J. W. Stanford, Cartersville, February 23, 1958
W. E. Thomasson, Carrollton, June 30, 1958
Cleveland Thompson, Waynesboro, August 5, 1958
W. A. Walker, Cairo, February 20, 1958
J. Calvin Weaver, Atlanta, April 20, 1958
A. J. Whelchel, Cordele, December 15, 1958
Edward O. White, Madison, June 18, 1958

Specialty Society Luncheons and Dinners

Certain specialty societies plan to have luncheons on Sunday, Monday and Tuesday and dinners on Sunday night during the Association's Annual Session. These events are listed in the official program even though they are not part of the official program, so please check there for specific time and place.

Woman's Auxiliary

The Woman's Auxiliary to the Medical Association of Georgia will have its Registration Desk in the Main Lobby of the Bon Air Hotel. Auxiliary meetings and exhibits will be held in the Partridge Inn which is just across the street from the Bon Air Hotel. The Auxiliary Registration Desk will be open Sunday, May 17, from 11:00 A.M. to 5:00 P.M.; Monday, May 18, from 8:30 A.M. to 3:30 P.M. and Tuesday, May 19, from 9:00 A.M. to 12:00 noon. The complete program giving times and locations of the meetings of the 34th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia will be found beginning on page 149.

Information

Social Events

Information about Social Events planned in conjunction with the MAG Annual Session and the necessary tickets will be available at the MAG Official Registration Desk. Your cooperation in purchasing your tickets for these social events at the time you register is requested. Accommodations for social events are limited and the sponsoring groups cannot be held responsible unless everyone cooperates in this regard. Alumni dinners for the Medical College of Georgia and the Emory University School of Medicine have been planned and are listed in the program for Monday evening, May 18.

Scientific Exhibits

Scientific Exhibits will be displayed just adjacent to the Bon Air Hotel Lobby. These exhibits are of great interest to the members of the medical profession. They are prepared by physicians who will be on hand to discuss the exhibits with you. All members are urged to visit each and every scientific exhibit in the interest of professional education.

"Hospital Staphylococcal Infections-Epidemiology and Control": Andrea J. Nahmias, M.D., and John T. Godwin, M.D., Atlanta, Georgia.

"Enemas and Laxatives": Leonard J. Rabhan, M.D., and Nathan B. Rabhan, B.S., Savannah, Georgia.

"Hysterographic Demonstration of Uterine Pathology": Henry E. Steadman, M.D., Atlanta, Georgia.

"Lung Changes in Heart Disease": Joseph Chang, M.D., and William A. Nelson, M.D., Atlanta, Georgia.

"Congenital Chorioretinitis in Schools for the Blind": John R. Fair, M.D., Augusta, Georgia.

"Central Nervous System Neoplasms": John T. Godwin, M.D., Robert Mabon, M.D., William E. Coles, M.D., and Pyrrha Grodman, M.D., Atlanta, Georgia.

"Poison Control Centers": An exhibit by the Accident Prevention Unit, Georgia Department of Public Health, H. C. Steed, Jr., MPH, Director, Atlanta, Georgia.

"An Exhibit by the National Medical Foundation for Eye Care": Sponsored by John R. Fair, M.D., Augusta, Georgia.

"The Treatment of Cardiac Arrhythmias": Zeb Lee Burrell, Jr., M.D., and William C. Gittinger, M.D., Milledgeville, Georgia.

Commercial Exhibits

Approximately 55 commercial exhibits are displayed in exhibit booths in corridors and rooms adjacent to the main meeting hall, Crystal Room, Bon Air Hotel. These exhibits will give up-to-date information on the latest products and services available to the profession.

It is *extremely* important that you visit each of these exhibits and register with the exhibitor. Your cooperation is requested since these displays are designed and shown specifically for your benefit. The exhibitors play an extremely important role in making this annual session possible and the Association Exhibit Committee strongly urges your participation in this area of Association activity.

Booth Number

Name of Company

- 1 Dictaphone Corporation, Atlanta, Ga.
- 2 Schering Corporation, Bloomfield, New Jersey
- 3 Pfizer Laboratories, Brooklyn, New York
- 4 A. H. Robins Company, Richmond, Virginia
- 5 Estes Surgical Supply Company, Atlanta, Georgia
- 6 Wm. P. Poythress & Company, Inc., Richmond, Virginia
- 7 Knoll Pharmaceutical Company, Orange, New Jersey
- 8 A. S. Aloe Company, Chamblee, Georgia
- 9 Carnation Company, Los Angeles, California
- 11 Sandoz Chemical Works, Inc., Hanover, New Jersey
- 14 Desitin Chemical Company, Providence, Rhode Island
- 15 Parke Davis and Company, Detroit, Michigan
- 16 Merck, Sharpe and Dohme Company, Inc., Philadelphia, Pennsylvania
- 17 Davies, Rose and Company, Ltd., Boston, Massachusetts
- 18 Surgical Selling Company, Atlanta, Georgia
- 21 Geigy Pharmaceutical Company, Inc., New York, New York.
- 22 Ciba Pharmaceutical Products, Summit, New Jersey
- 24 Tailby-Nelson Company, New York, New York
- 27 Marks Surgical Supply Company, Augusta, Georgia

Information

- | | |
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| <p>28 Medco Products Company, Tulsa, Oklahoma</p> <p>31 Wm. S. Merrell Company, Cincinnati, Ohio</p> <p>32 Mead Johnson and Company, Evansville, Indiana</p> <p>33 George A. Breon and Company, New York, New York</p> <p>34 Ross Laboratories, Columbus, Ohio</p> <p>35 Upjohn Company, Kalamazoo, Michigan</p> <p>38 Wachtel's Physician Supply Company, Savannah, Georgia</p> <p>40 Van Pelt and Brown, Inc., Richmond, Virginia</p> <p>41 J. A. Majors Company, Atlanta, Georgia</p> <p>42 Coca Cola Company, Atlanta, Georgia</p> <p>43 Bordons Prescription Products Div., New York, New York</p> <p>44 Ortho Pharmaceutical Corporation, Raritan, New Jersey</p> | <p>45 Eli Lilly and Company, Indianapolis, Indiana</p> <p>46 The Lanier Company, Atlanta, Georgia</p> <p>47 Warren-Teed Products Company, Columbus, Georgia</p> <p>48 Abbott Laboratories, N. Chicago, Illinois</p> <p>49 E. L. Uatch Company, Stoneham, Massachusetts</p> <p>50 Winthrop Laboratories, New York, New York</p> <p>51 U. S. Vitamin Company, New York, New York</p> <p>52 Eaton Laboratories, Norwich, New York</p> <p>53 Westwood Pharmaceuticals, Buffalo, New York</p> <p>54 Chas. C. Haskell and Company, Richmond, Virginia</p> <p>55 G. D. Searle and Company, Chicago, Illinois</p> |
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Fifty Year Members

The following list contains the names of all of the members of the Medical Association of Georgia who as of this year, 1959, have practiced medicine for fifty years. It does not record the names of physicians who have already received gold membership cards. This is the class of 1958 only.

Henry M. S. Adams	Atlanta
James C. Anderson	Macon
David P. Belcher	Pelham
Charles S. Floyd	Lindale
Clayborne A. Harris	The Rock

William W. Hillis	Sardis
George F. Klugh	Sanford, N. C.
Hal C. Miller	Atlanta
Henry H. Olliff	Register
Emory R. Park	LaGrange
Stephen C. Redd	Atlanta
Charles H. Richardson, Sr.	Macon
John L. Taylor	Franklin
Marcus L. Webb	Tifton
Lehman W. Williams	Savannah
Gabe W. Willis	Ocilla

VOTING RULES

By-Laws, Chapter V, Election of Officers

SECTION 3, METHOD. The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SECTION 4, TIME. Voting shall take place during the hours of the scientific program up to the beginning of the last meeting on the last day of the annual session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.

EACH YEAR your State Medical Association convenes an annual meeting for the entire membership in Georgia. The three main objects of the MAG Annual Session are to provide a wide range of scientific data; to conduct the business of the Association by the membership and their elected delegates; and certainly, to offer the fellowship and cordiality enjoyed by the profession at the many social affairs and specialty society events.

Scientific meetings, meetings of the House of Delegates, general business sessions, social hours, alumni dinners — this makes an annual session. Another highlight is the Woman's Auxiliary meetings, luncheons and tours which are planned to interest each physician's wife. Mix these three days of medical get-together with the genial hospitality of Augusta and we cannot fail to have an outstanding meeting.

Statistically speaking, there are 11 nationally known out-of-state doctors and 53 Georgia physicians participating in the scientific presentations. Your specialty societies have planned 16 luncheons and dinners. Also scheduled are the two traditional sessions of your House of Delegates and two General Business sessions for the entire membership. Elections, awards, and honors also highlight the program.

Not last nor least is the Scientific Exhibits and Commercial Exhibits displayed for your benefit. These displays will graphically show the latest developments in medicine and the exhibitors will be at their booths to inform you further on the nature of the exhibit.

All this has been planned for you, the doctor. All this needs for a successful meeting is for you to attend and participate! In my capacity as Association President, I wish to personally invite and urge you to be with us. Augusta—May 17-20—See you there!

Lee Howard Sr. M.D.

President, Medical Association of Georgia



Lee Howard, Sr., Savannah

GUEST SPEAKERS

George J.
Thomas, M.D.
Pittsburgh, Pa.



GEORGE J. THOMAS, M.D., of Pittsburgh, Pennsylvania, Director of the Department of Anesthesiology at the General Hospital and Rehabilitation Institute in Pittsburgh, will present a paper on "Fire and Exposure Hazards in Hospitals and Their Control" on Monday, May 18, at 2:30 P.M. Dr. Thomas is

Professor of Surgery and Chairman of the section of Anesthesiology at the University of Pittsburgh School of Medicine and since 1938 Dr. Thomas has been active in the research of the prevention of fires and exposure with flammable anesthetic agents and has worked in close cooperation with the explosive division of the United States Bureau of Mines.

Dr. Thomas' lecture and demonstration will cover the following:

(1) Factors conducive to fires and explosions with flammable anesthetics; (2) the value of conductive floors and efficient grounding devices in minimizing explosion hazards in anesthetizing areas; (3) a demonstration of electrostatic charges igniting flammable anesthetic vapors; (4) the danger of various types of material in producing electrostatic charges of sufficient intensity to ignite flammable anesthetic mixtures; (5) a demonstration of the danger of non-conductive mattresses on operating and delivery room tables; and (6) the value of the non-flammable anesthesia technique in preventing fires and explosions in hospitals.

Paul Dudley
White, M.D.
Boston, Mass.



PAUL DUDLEY WHITE, M.D., Boston, Massachusetts, will present the Association Abner W. Calhoun Lectureship on the subject "Cardiovascular Disease in the Light of the Long Follow-Up" on Tuesday, May 19, at 12:00 noon. Dr. White certainly needs no introduction to the medical profession. He is a national authority in the field of cardiovascular diseases. Dr. White received his medical degree from Harvard University Medical School and interned at the Massachusetts General Hospital. Among his other honors, his most recent attainments are the Distinguished Service Medal of the American Medical Association; Consultant to the Surgeon General, U. S. Army and Navy, and President of the International Society of Cardiology Foundation. The entire Association membership may have the privilege of attending the Calhoun Lectureship as it has traditionally been a general session.

A summary of Dr. White's paper is as follows:

Diseases of the heart and blood vessels may be acute, subacute, or chronic. Most of the studies that have been made and reported in the past have been from the point of view of the acute or subacute stages. Although heart disease has long been referred to as a chronic disease, there have been far too few long follow-up surveys and it is this particularly that I wish to emphasize in my Calhoun Lecture.

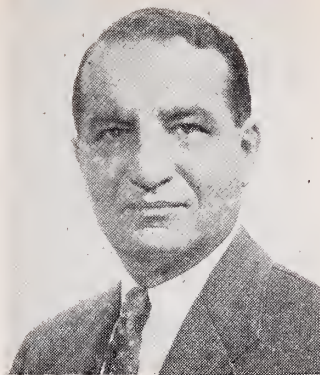
In medieval days heart disease was supposed to cause rapid death, in fact, it was traditional to think that if the heart were affected, death would come at once. It was at this time that some of the early postmortem examinations demonstrated obviously chronic changes in the heart and blood vessels. Now we know that the majority of patients with cardiovascular disease survive to live for a good many years. However, the natural history of this disease is being interrupted by new types of treatment, medical or surgical, some of them very effective, but for the sake of adequate controls, it is important to know what the disease itself was like over the years before the advent of the new treatment.

In my own experience, there have been many patients with heart and blood vessel diseases of one kind or another who have survived for many years, in fact sometimes for several decades, despite cardiovascular abnormalities without the help of the latest therapy. A few serious conditions, however, have almost invariably precluded much longevity. Such conditions have included subacute bacterial endocarditis, a high degree of cardiovascular syphilis, extreme degrees of aortic regurgitation, and malignant hypertension.

But now these diseases can all be altered and a good many victims saved and benefited by the newly developed treatment. Other kinds of disease that were formerly thought quickly fatal, such as coronary thrombosis, serious congenital defect such as the tetralogy of Fallot, and marked enlargement of the heart have on occasion recovered even before the days of specific treatment by medicine or surgery.

My experience with some of these patients in our comparison of current and future prospects of such patients is the reason for this presentation.

Louis K.
Diamond, M.D.
Boston, Mass.



LOUIS K. DIAMOND, M.D., Boston, Massachusetts, is Associate Professor of Pediatrics at Harvard Medical School. Dr. Diamond is also the Associate Chief, Medical Service, Children's Medical Center, Boston; Director, Hematology Laboratory and Blood Bank, Children's Medical Center, Boston;

and Director of the Blood Grouping Laboratory of Boston.

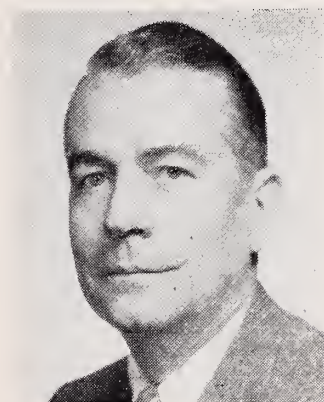
Dr. Diamond will make a presentation on the subject "The Inadequacies of Routine Bleeding and Clotting Time Determination" on Sunday, May 17, at 2:30 P.M. A summary of this paper follows:

A strong plea is made for the abandonment of routine presurgery tests of bleeding and clotting times on the basis of such evident inherent limitations as the occurrence of false-positive reactions and the fact that a normal result in no way assures a normal bleeding and clotting status in the patient. A carefully taken family history and past history and an adequate physical examination, as well as the examination of a peripheral blood smear, are suggested as being far more informative and effective screening procedures.

If reliable laboratory studies are indicated, accurate platelet estimations and the complete battery of clotting tests must be done.

Dr. Diamond will also present an address on the subject of "The Danger of Jaundice in the New-born" on Monday, May 18, at 10:00 A.M.

Louis M.
Orr, M.D.
Orlando, Fla.



LOUIS M. ORR, M. D., Orlando, Florida, President-Elect of the American Medical Association and a distinguished urologist will address the entire membership on the subject "Time for Medicine's Re-Entry" at the Association General Session, Monday, May 18, at 11:50 A.M.

A former president of the Southeastern section of the American Urological Association, Dr. Orr is a practicing urologist in Orlando. Graduating from Emory University School of Medicine in 1924, Dr. Orr served as a resident in urology and general surgery at the Lakeside Hospital in Cleveland prior to his moving to Orlando.

Dr. Orr has had a long and distinguished career with the American Medical Association, having served as Vice-Speaker of the House of Delegates, Chairman of the Federal Medical Services Committee, and Ex-Officio member of the Council on Constitution and By-Laws and also a member of the Council on Medical Service. He has made more than fifty contributions to the Scientific Literature.

Dr. Orr will also present a paper on "Evaluation of Renal Function by Radioactive Means" on Monday, May 18, at 3 P.M.

William H. Ramey
Rochester, N. Y.



MR. WILLIAM H. RAMEY, Eastman Kodak Company, Medical Division, Rochester, New York is the Supervisor in Medical Division to the East-

man Kodak Company. Born in Protection, Kansas, Mr. Ramey attended the Kemper Military School at Boonesville, Missouri and received an A.B. at the University of Kansas. He also attended the School of Business Administration.

Mr. Ramey will make a presentation on "The Radiologist and the Film Processing Problem" on Monday, May 18, at 3:00 P.M. A brief summary of the presentation is as follows:

This paper defines the processing problem and discusses the value to be found in its correct solution when (a) the conventional hanger and tank methods of processing are carried out and (b) where the new, rapid, automatic roller-transport film processor is used.

A quick look into the future concludes this paper.

Arthur C.
Allen, M.D.
Miami, Fla.



ARTHUR C. ALLEN, M.D., Miami, Florida is currently Professor of Pathology at the University of Miami Medical School, Attending Pathologist at the Jackson Memorial Hospital, a Consultant Pathologist at the VA Hospital, Coral Gables, Florida and also a Consultant Pathologist at Hunterdon Medical Center, Flemington, New Jersey.

Dr. Allen, a graduate of the University of California Medical School, served his internship at San Francisco County Hospital. Dr. Allen will present a paper on the subject of "Clinicopathologic Meaning of the Nephrotic Syndrome" on Tuesday, May 19, at 10:15 A.M. A brief summary of this paper follows :

The nephrotic syndrome, "pure" or "mixed," is associated with one of the following lesions: (1) membranous glomerulonephritis, (2) lobular glomerulonephritis, (3) diabetic glomerulosclerosis, (4) glomerular amyloidosis, and 5) bilateral renal vein thrombosis.

It is suggested that in all instances of the nephrotic syndrome, the rare instance of that due to renal vein thrombosis possibly excepted, one of the foregoing types of glomerular lesions is present and is the basis for the proteinuria which is the engine to the train of signs and symptoms known as the nephrotic syndrome.

The renal lesion responsible for "lipid nephrosis" of children as well as adults, or the so-called "nephrotic phase of glomerulonephritis," is either diffuse membranous or lobular glomerulonephritis: the former is the more common, particularly among children.

Dr. Allen will also present a paper on "Clinicopathologic Correlation of Nevi, Juvenile Melanomas and Malignant Melanomas" on Tuesday, May 19, at 2:30 P.M. A brief precis of this paper follows:

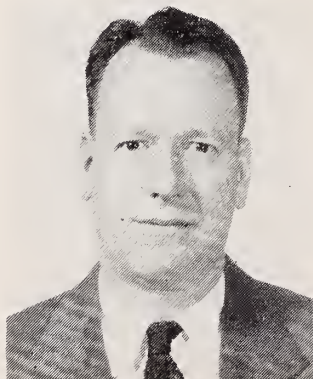
Lesions in adult life are not infrequently erroneously diagnosed malignant melanomas although they are actually benign juvenile melanomas that have persisted beyond puberty. Puberty is not necessarily the diagnostic demarcation. In other words, the histology of the juvenile melanomas, as herein described, may transcend in application the fact that the patient is an adult.

Superficial melanocarcinomas, as herein defined, should be segregated from the more deeply invasive tumors for diagnostic as well as prognostic reasons. The superficial melanocarcinomas, as a group, have an appreciably better prognosis than the more deeply infiltrative tumors.

The epidermal junctional nevus, or the junctional component of the compound nevus, is the source of the melanocarcinomas of the skin and of mucous membranes, the rare malignant blue nevus excepted, of course. Approximately, one of every ten cutaneous melanocarcinomas is superimposed on compound nevi or juvenile melanomas.

A patient with a melanocarcinoma exhibits a diathesis for the activation of junctional nevi in various parts of the body but particularly in the vicinity of the primary tumor. This latter phenomenon is a contributory factor in local recurrences.

John Arthur
Evans, M.D.
New York, N. Y.



JOHN ARTHUR EVANS, M.D., Professor of Radiology, Cornell Medical College, will give an address on May 17, 1959 at 2:50 P.M. on "The Roentgen Diagnosis of Lesions of the Spine." The following is a summary of Dr. Evans' presentation:

"The fields of interest of the orthopedic surgeon, neurologist, neurosurgeon, psychiatrist, and radiologist converge to a greater extent at the spine than at any

other part of the body. In lesions of the spine, be they congenital or acquired, trauma, infection, or tumor the services of all of these specialists are frequently required to reach an exact diagnosis. Lesions of the spine frequently involve the nervous system, therefore, the neurologist as well as the radiologist is often called upon to determine the site of the lesion and depending upon the type of lesion the neurosurgeon or orthopedic surgeon provides definitive treatment. While I know of no primary spinal disease which causes a psychosis, the psychiatrist is not completely neglected because there are occasions when persistent symptoms but negative objective findings raise the question of functional disease and the psychiatrist helps in evaluating the patient's complaints. A number of case reports are presented illustrating the above statements."

Dr. Evans is a graduate of Cornell Medical College. He is Radiologist-in-Chief, The New York Hospital-Cornell Medical Center. He is President of The New York Roentgen Society 1958-1959, Consultant in Radiology to the Veterans Administration-New York area, and National Consultant in Radiology to the United States Air Force.

M. Digby
Leigh, M.D.
Los Angeles, Calif.



M. DIGBY LEIGH, M.D., Director of Anesthesia, Children's Hospital, Los Angeles, will give an address on Sunday, May 17, at 3:00 P.M. entitled "Pediatric Anesthesiology For Head And Neck Surgery." In this talk Dr. Leigh will discuss the following ideas:

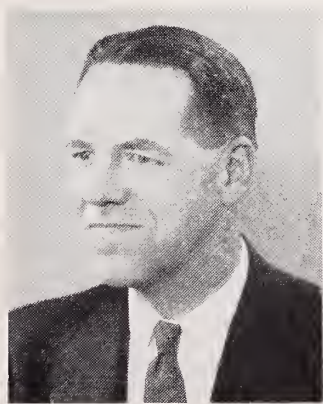
Pediatric Anesthesiology for head and neck surgery which includes operations such as tonsillectomy and adenoidectomy, mastoidectomy, tym-

panoplasty, cheiloplasty (cleft lip repair), incision of retropharyngeal abscess, esophagoscopy, bronchoscopy, tracheostomy, extraction and repair of teeth, and the operation for choanal atresia, is one of the most difficult and challenging branches of pediatric anesthesiology, since unvariably the operation itself or the position of the patient threatens the patency of the airway.

For this reason, one cannot overlook the advantages offered by the endotracheal technique for most of these operations. Some of these advantages are: it ensures a patent airway; it permits pulmonary ventilation; and it removes the anesthesiologist from the operative field, thereby facilitating the work of the surgeon.

Dr. Leigh is Director of Anesthesia, Children's Hospital, Los Angeles, California; Professor of Surgery (Anesthesia) University of Southern California. Dr. Leigh is a graduate of McGill University with three years training in Anesthesiology at Madison, Wisconsin. He is a Diplomat of the American Board of Anesthesiology and is the author of a book, "Pediatric Anesthesia." He has another book in the process of publication, "Pediatric Anesthesiology."

Edgar A.
Hines, Jr., M.D.
Rochester, Minn.



EDGAR A. HINES, JR., M.D., Mayo Clinic, Rochester, Minnesota, is the Associate in Medicine at the Mayo Clinic; Professor of Medicine at the Mayo Foundation at the Graduate School at the University of Minnesota, Rochester, Minnesota; and head of the section of Medicine at the Mayo Clinic. Born in South Carolina, Dr. Hines graduated from the Medical College of the State of South Carolina and interned at St. Elizabeth Hospital, Richmond, Virginia. Dr. Hines has made many contributions to the literature and will present a paper on "Anticoagulants: How Come, How Good, and How

Now?" on Monday, May 18, at 10:30 A.M. A precis of this paper follows:

The development of anticoagulant drugs has been a logical, though not as yet ideal approach to an important area of preventive medicine. Interest in anticoagulants has stimulated fundamental investigation and has indirectly added to our knowledge of basic processes concerned with intravascular clotting of the blood. Knowledge concerning the effects of anticoagulants and their use in treatment has increased continuously since these drugs were first introduced about 20 years ago. It is now accepted widely that this is the best medical weapon available for the prevention of thrombosis and embolisms.

The short-term or long-term use of anticoagulants introduces complicated processes in the control of these drugs in that the drugs have to be administered meticulously and in the case of the coumarin type of drugs, under accurate laboratory control. Heparin has a special role in the prevention of thrombosis and embolism and requires a different method of control. The very name "anticoagulant" implies a small calculated risk of bleeding when these drugs are used. The danger of serious bleeding must always be respected but it rarely occurs in a carefully supervised program of treatment.

Newer anticoagulants are being introduced and their virtues strongly extolled by their manufacturers. The physician should weigh carefully the advantages and disadvantages of a new preparation before he replaces an anticoagulant that he is accustomed to using by one with which he is less familiar. Warfarin Sodium (Coumadin®), the popular anticoagulant of the day, has some advantages over Dicumarol®. However, these advantages are not great except when an anticoagulant

must be given intravenously. The newest coumarin anticoagulants, including Coumadin®, have the economic disadvantage of being about five times as costly as Dicumarol®. Any one of the half dozen oral anticoagulants now available can be used effectively and safely by any physician who is experienced in the use of that particular product and who has available laboratory facilities for accurate prothrombin determinations.

Dr. Hines will also present a paper on "The Problem of Venous Thrombosis and Pulmonary Embolism" on Monday, May 18, at 3:30 P.M. The summary of this paper follows:

Contrary to the predictions of 10 or 15 years ago that early ambulation and the use of antibiotics to control postoperative infection would largely prevent thrombophlebitis and pulmonary embolism, we still have these problems with us. I have been fortunate to gain such experience as I have had with these problems during the pre- and post-anticoagulant era. I have seen the situation change radically since the introduction of anticoagulants about 20 years ago. I do not believe that more recently introduced preventive measures such as the use of elastic supports on the lower extremities, elevation and exercise of the lower

extremities for bed patients or the use of fibrinolytic agents have materially affected the problem of venous thrombosis and embolism. We are still largely dependent on anticoagulants for the prevention and treatment of these complications. Obviously, it is not practical to protect every patient from the possibility of the occurrence of venous thrombosis or embolism. Consequently, the greatest need at this time is for some test which will reliably predict those who are most likely to develop such complications.

There also is a need for a simpler and safer method of producing a therapeutic anticoagulant effect. However, since in order to prevent thrombosis we impair some important steps in the process of blood coagulation, I doubt that it will be possible to greatly simplify this type of treatment. The investigation of the practical use of enzymes that alter or destroy fibrin is a logical step towards more effective treatment when thrombosis has already occurred. However, these agents are still in the experimental stage of development and are not at present applicable for general use. I have found Butazolidin® of value in treating some patients with superficial phlebitis but I have not used it in patients with deep or large vein thrombosis. When venous thrombosis involving large veins has already occurred, some fundamental principles of treatment should be followed in order to prevent the subsequent development of the complications of chronic venous insufficiency.

Curtis P.
Artz, M.D.
Jackson, Miss.



CURTIS P. ARTZ, M.D., of Jackson, Mississippi, Associate Professor of Surgery at the University of Mississippi Medical Center, will present a paper on "The Early Management of the Burn Patient" on Monday, May 18, at 9:30 A.M. A summary of the paper is as follows:

As soon as a burn patient is seen, it is important to appraise the seriousness of the burn injury. The percentage of body surface burned and the depth of the burn determine the volume of tissue destroyed and thereby, the type of care and prognosis that follows. It appears that major burns should be treated in special centers where adequate facilities are available and minor burns may be treated in either the community hospital or as out patients. It is essential that the following be accomplished early: need for tracheotomy, intravenous morphine for pain and apprehension, tetanus prophylaxis, cut down cannula for moderate burns, and preparation for local care.

Replacement therapy should be planned allowing for the size of the patient and the extent of the burn. It should be administered in accordance with the response of the patient. A complete outline of the step by step procedures to be carried out in the emergency

room for a major burn will be discussed. Local care can be accomplished by either dressings or the exposure method. Dressings should be occlusive, bulky, absorptive and put on with even resilient compression. They should be changed every five days.

Dr. Artz will also present and discuss "Early Grafting of the Burn Patient" Tuesday, May 19, at 10:45 A.M. His paper is summarized as follows:

Irrespective of whether local care has been by the exposure method or by dressings, it is imperative that third degree burns be covered as early as possible. A third type of local care is immediate excision with grafting. This is limited to small well delineated burns. The use of the electric dermatome has been one of the great advances in burn care in the past ten years.

Most flat surfaces accept skin grafts when they are placed on a "lay on method." Lightly impregnated carbowax gauze and large one piece dressings are preferred over the grafted areas.

Occasionally it is necessary in very extensive burns to use homografts as temporary cover for the wound. Certain areas such as the face, hands, and points of flexion deserve priority for early grafting. A thorough discussion of a simplified grafting technique gathered from the experience in 1000 patients will be outlined.

Dr. Artz, a graduate of Ohio State University Medical School, interned at Baltimore City Hospital and served residencies at Camden Clark Memorial Hospital, Parkersburg, West Virginia, University Hospital at Ohio State University, Columbus, Ohio, and Brooke Army Medical Center, Ft. Sam Houston, Texas. At present, Dr. Artz is a consultant in surgery at the VA Hospital, Jackson, Mississippi, civilian consultant to the Surgeon General, U. S. Army, Washington, D. C., and a member of the Surgeon General's Advisory Committee on Nutrition. He is also a member of the Committee on Trauma of the American College of Surgeons.

The Program

SUNDAY AFTERNOON, MAY 17

Social Events

(Not a part of Official Program)

Sunday Noon, May 17

NOTE: Make reservations in advance with chairman if possible.

12:00 Georgia Society of Dermatology Social and Luncheon
3201 Huxley Drive, Augusta
J. Malcolm Bazemore, Augusta, Chairman

12:00 **Dermatology Section Meeting**
3201 Huxley Drive (corner Huxley and Almond Road)

PRESIDING

J. M. Bazemore, Augusta

2:00 **Radiology, Orthopedics and Psychiatry-Neurology-Neurosurgery Joint Section**

(ALL PHYSICIANS INVITED)

Crystal Room, Bon Air Hotel

PRESIDING

Augustin S. Carswell, Augusta

2:00 **LOW BACK PAIN**

Thomas P. Goodwyn, Atlanta

2:25 **PATHOLOGICAL ANATOMY WITH THE DIFFERENTIAL DIAGNOSIS OF LOW BACK PAIN**

Paul Reith, Atlanta

2:50 **THE ROENTGEN DIAGNOSIS OF LESIONS OF THE SPINE**

John A. Evans, New York, New York

3:20 **CLOSED CORRECTION FOR THE DISC SYNDROME**

Darius Flinchum, Atlanta

3:40 **NEUROSURGICAL TREATMENT OF THE LUMBAR DISC**

Edgar Fincher, Atlanta

4:05 **PSYCHIATRIC ASPECTS OF LOW BACK PAIN**

Bernard C. Holland, Atlanta

4:30 **HUMAN RADIATION EXPOSURE—FACTS AND FANCIES**

H. Stephen Weens, Atlanta

4:50 **DISCUSSION PERIOD**

2:00 **Pediatrics, Anesthesiology and EENT Joint Section**

(ALL PHYSICIANS INVITED)

Press Room, Bon Air Hotel

PRESIDING

William O. White, Augusta

2:00 **SOME CLINICAL APPROACHES TO COAGULATION PROBLEMS IN CHILDREN**

Preston Ellington, Augusta

2:30 **THE INADEQUACIES OF BLEEDING AND CLOTTING TIME DETERMINATION**

Louis K. Diamond, Boston, Massachusetts

3:00 **PEDIATRIC ANESTHESIA FOR HEAD AND NECK SURGERY**

M. Digby Leigh, Los Angeles, California

3:30 **CONGENITAL TOXOPLASMOSIS OCULAR ASPECTS OF THE DISEASE**

John R. Fair, Augusta

4:00 **WOOD-TICK PARALYSIS (MOVIE AND COMMENT)**

Frank Anderson, Augusta

4:30 **THE CLINICAL EVALUATION OF TONOGRAPHY**

Franklyn P. Bousquet, Savannah

4:45 **MAG Delegates Registration**
Crystal Room, Bon Air Hotel

5:00 **House of Delegates Meeting**
Crystal Room, Bon Air Hotel

PRESIDING

Thomas W. Goodwin, Augusta,
Speaker of the House

5:00 **ORDER OF BUSINESS (See Delegate's Handbook)**

REPORT OF PRESIDENT WOMAN'S AUXILIARY TO MAG

Mrs. Luther H. Wolff, Columbus

Social Events

(Not a part of Official Program)

Sunday Night, May 17

NOTE: Make reservations in advance with chairman if possible.

6:00 Georgia Radiological Society Social and Dinner
Press Room, Bon Air Hotel

Russell Wigh, Augusta, Chairman

6:00 Georgia Psychiatric Association Social and Dinner
Augusta Room, Bon Air Hotel

E. J. McCranie, Augusta, Chairman

7:00 Georgia Orthopedic Society Dinner
Timmerman's Lodge, Golden Camp Road

A. S. Carswell, Augusta, Chairman

7:00 House of Delegates and Exhibitors Social Hour
(Wives of Delegates invited)
Ye Olde Pump Room, Bon Air Hotel

8:00 Georgia Pediatric Society, Georgia Society of Anesthesiology and Georgia Society of Ophthalmology and Otolaryngology Dinner
Golf Room, Bon Air Hotel

W. A. Wilkes, Augusta, Chairman

8:30 **General Session (G. P. Night)**

(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)

Crystal Room, Bon Air Hotel

PRESIDING

Sage Harper, GAGP President, Douglas
AN ADDRESS

Honorable S. Ernest Vandiver,
Governor, State of Georgia

MONDAY MORNING, MAY 18

8:00 **MAG Reference Committees**

8:00 REFERENCE COMMITTEE NO. 1
Card Room, Bon Air Hotel

- 8:00 REFERENCE COMMITTEE NO. 2
Room 462, Bon Air Hotel
- 8:00 REFERENCE COMMITTEE NO. 3
Room 741, Bon Air Hotel
- 9:00 General Session (G. P. Day)**
(ALL PHYSICIANS INVITED)
Crystal Room, Bon Air Hotel
PRESIDING
Sage Harper, Douglas
- 9:00 THE ROLE OF THE GENERAL PRACTITIONER IN MENTAL HEALTH
Francis M. Parks, Carrollton
- 9:30 THE EARLY MANAGEMENT OF THE BURNED PATIENT
Curtis P. Artz, Jackson, Mississippi
- 10:00 THE DANGER OF JAUNDICE IN THE NEWBORN
Louis K. Diamond, Boston, Massachusetts
- 10:30 ANTICOAGULANTS: HOW COME, HOW GOOD, AND HOW SOON?
Edgar A. Hines, Rochester, Minnesota
- 11:15 CALCIFICATIONS OF THE LIVER
J. Spalding Schroder, Atlanta
- 9:00 Georgia Radiological Society Business Meeting and Roentgen Interpretation Session**
Augusta Room, Bon Air Hotel
PRESIDING
Heinz S. Weens, Atlanta
- 9:00 BUSINESS MEETING
- 10:30 PANEL: ROENTGEN INTERPRETATION SESSION
MODERATOR
Ted F. Leigh, Atlanta
PANELISTS:
John A. Evans, New York, New York
Stephen W. Brown, Augusta
Herbert M. Olnick, Macon
James V. Rogers, Jr., Atlanta
- 11:45 MAG General Business Session**
(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)
Crystal Room, Bon Air Hotel
PRESIDING
Lee Howard, Sr., Savannah, President, Medical Association of Georgia
- 11:50 TIME FOR MEDICINE'S RE-ENTRY
Louis M. Orr, Orlando, Florida, President-Elect, American Medical Association
PRESIDING
George H. Alexander, Forsyth, First Vice-President
PRESIDENT'S ADDRESS
Lee Howard, Sr., Savannah, President
PRESIDING
Lee Howard, Sr., Savannah, President
NOMINATION OF OFFICERS
(Announcement of Tellers Committee)
President-Elect
First Vice President
Second Vice President
AMA Delegate (Term beginning January 1, 1960)

AMA Alternate Delegate (Term beginning January 1, 1960)
Fifth District Councilor
Fifth District Vice Councilor
Sixth District Councilor
Sixth District Vice Councilor
Seventh District Councilor
Seventh District Vice Councilor
Eighth District Councilor
Eighth District Vice Councilor

Social Events

(Not a part of Official Program)

Monday Noon, May 18

NOTE: Make reservations in advance with chairman if possible.

- 12:45 Georgia Urological Society Luncheon
Penthouse, Bon Air Hotel
Robert Rinker, Augusta, Chairman
- 1:00 Georgia Chapter, American College of Chest Physicians and Trudeau Society Luncheon
Chinese Room, Bon Air Hotel
C. H. Carter, Augusta, Chairman
- 1:00 Georgia Radiological Society Luncheon
Oglethorpe Lounge, Bon Air Hotel
Russell Wigh, Augusta, Chairman

MONDAY AFTERNOON, MAY 18

- 2:30 MAG Reference Committees**
- 2:30 REFERENCE COMMITTEE NO. 4
Card Room, Bon Air Hotel
- 2:30 REFERENCE COMMITTEE NO. 5
Room 462, Bon Air Hotel
- 2:30 REFERENCE COMMITTEE NO. 6
Room 741, Bon Air Hotel
- 2:30 Surgery, Industrial Surgery, Anesthesiology, Urology, and Orthopedics Joint Section**
(ALL PHYSICIANS INVITED)
Crystal Room, Bon Air Hotel
PRESIDING
A. S. Carswell, Augusta
- 2:30 FIRE AND EXPLOSION HAZARDS IN HOSPITALS AND THEIR CONTROL
George Thomas, Pittsburgh, Pennsylvania
- 3:00 EVALUATION OF RENAL FUNCTION BY RADIOACTIVE MEANS
Louis M. Orr, Orlando, Florida
- 3:30 Mallet Finger
Darius Flinchum, Atlanta
- 3:50 FIBULAR TRANSPLANTS FOR DEFECTS IN TIBIA
W. P. Warner and Robert T. Willingham, Jr., Atlanta and Jonathan Swift, Marietta
PRESIDING
Harry D. Pinson, Augusta
- 4:10 INTERESTING BILIARY TRACT LESIONS
John N. McClure, Atlanta
- 4:25 COMPLICATIONS OF GALLSTONES
P. F. Brown, Jr. and P. K. Dixon, Jr., Gainesville
- 4:40 SURGICAL ASPECTS OF BILIARY TRACT DISEASE
Charles H. Richardson, Jr., Macon

**2:30 Medicine, Diabetes, Dermatology,
and Chest Joint Section**

(ALL PHYSICIANS INVITED)

Press Room, Bon Air Hotel

PRESIDING

Harry T. Harper, Jr., Augusta

2:30 THE CHOICE OF A DIURETIC

Thomas Findley and James A. Kemp,
Augusta

**2:50 LIVER FUNCTION TESTS—THE MECHAN-
ISM AND MEANING**

John T. Galambos, Atlanta

**3:10 AN ATHEROGENIC PROFILE—ITS USE IN
MANAGING THE CORONARY PATIENT**

Curtis G. Hames, Claxton

**3:30 THE PROBLEM OF VENOUS THROMBOSIS
AND PULMONARY EMBOLISM**

Edgar H. Hines, Jr., Rochester, Minnesota

**4:20 HYPERSENSITIVITY REACTIONS TO PENI-
CILLIN**

Edwin C. Evans, Atlanta

4:40 PYLORIC CHANNEL ULCER

Thomas J. Anderson, Jr., Atlanta

2:30 Radiology Section

(ALL PHYSICIANS INVITED)

Augusta Room, Bon Air Hotel

PRESIDING

Heinz S. Weens, Atlanta

**2:30 TUMORS OF THE ORBIT—ROENTGEN
DIAGNOSIS**

John A. Evans, New York, New York

**3:00 THE RADIOLOGIST AND THE FILM PROCESS-
ING PROBLEM**

Mr. William Ramey, Rochester, New York

**3:20 PROBLEMS ENCOUNTERED IN ESTABLISH-
ING A RADIOISOTOPE LABORATORY**

John R. McLaren, Atlanta

**3:40 GASTROGRAFIN—A MEDIUM FOR INTES-
TINAL ROENTGENOLOGY**

David Robinson, Savannah

4:00 INTERMISSION

**4:10 ROLE OF RADIATION THERAPY IN THE
TREATMENT OF CANCERS OF THE TONSIL**

John F. Dillon, Augusta

Presentation by Resident Physicians

**4:30 INTRAVENOUS CHOLANGIOGRAPHY IN THE
DIFFERENTIAL DIAGNOSIS OF THE ACUTE
ABDOMEN**

Henry Johnson, Atlanta

**4:45 EXCERPTS FROM A CINEFLUOROGRAPHIC
LIBRARY**

William F. Lindsey, Augusta

Social Events

(Not a part of Official Program)

Monday Evening, May 18

*NOTE: Make reservations in advance with chairman
if possible.*

**7:00 MEDICAL COLLEGE OF GEORGIA
ALUMNI DINNER**

Time and place to be announced

**7:00 EMORY UNIVERSITY SCHOOL OF
MEDICINE ALUMNI DINNER**

Time and place to be announced

TUESDAY MORNING, MAY 19

Tour

(Not a part of Official Program)

Tuesday Morning, May 19

9:00 Visit to Savannah River Plant of the Atomic
Energy Commission

John F. Dillon, Augusta, Coordinator

**9:00 Medicine, Diabetes, Dermatology,
and Chest Joint Section**

(ALL PHYSICIANS INVITED)

Crystal Room, Bon Air Hotel

PRESIDING

Raymond C. Arp, Atlanta

**9:00 VASCULAR CHANGES IN DIABETES
MELLITUS**

A. B. Chandler, Augusta

**9:15 CLINICAL MANIFESTATIONS OF VASCULAR
DISEASE IN DIABETES MELLITUS**

Arthur M. Knight, Jr., Waycross

9:30 ATHEROGENESIS IN DIABETES

Gerald R. Cooper, Atlanta

10:00 OCULAR SIGNS IN DIABETES MELLITUS

J. R. Fair, Augusta

**10:15 CLINICO-PATHOLOGICAL MEANING OF THE
NEPHROTIC SYNDROME**

Arthur Allen, Miami, Florida

**10:45 PANEL: CLINICAL PATHOLOGY IN DIA-
BETES MELLITUS**

MODERATOR

Nathan M. DeVaughn, Augusta

PANELISTS:

Arthur Allen, Miami, Florida

Walter Bloom, Atlanta

Arthur Knight, Waycross

Bruce Logue, Atlanta

Harry Harper, Augusta

Gerald Cooper, Atlanta

9:00 Surgery Section

(ALL PHYSICIANS INVITED)

Press Room, Bon Air Hotel

PRESIDING

William H. Moretz, Augusta

**9:00 RESPIRATORY ARREST FOLLOWING THE IN-
STALLATION OF NEOMYCIN IN THE PERI-
TONEAL CAVITY**

J. D. Martin, Jr., William B. Short, and
Jacob L. Hartley, Atlanta

**9:15 TREATMENT OF THROMBOSIS OF THE IN-
TERNAL CAROTID ARTERY**

Garland Perdue, Atlanta

**9:30 TEFLON GRAFTS IN DIRECT SURGERY OF
ARTERIOSCLEROSIS**

J. Harold Harrison, Atlanta

**9:45 SURGICAL TREATMENT OF OCCLUSIVE
VASCULAR DISEASES OF THE EXTREMITIES**

Julian K. Quattlebaum, Jr. and
D. W. Timms, Savannah

10:00 CANCER OF THE STOMACH

Milton Bryant, Atlanta

**10:15 GASTRECTOMY IN THE TREATMENT OF
DUODENAL ULCER**

Edwin L. Brackney, Augusta

- 10:45 GRAFTING IN BURNS
Curtis P. Artz, Jackson, Mississippi
- 11:15 MANAGEMENT OF TUMORS OF THE ESOPHAGUS
Sam Wilkins, Atlanta
- 11:30 RESULTS IN THE SURGICAL MANAGEMENT OF MITRAL STENOSIS
William E. Van Fleit and Osler A. Abbott, Atlanta
- 11:45 DELAYED RUPTURE OF THE DIAPHRAM—A PRESENTATION OF THREE CASES WITH SOME PERTINENT OBSERVATIONS
Robert H. Vaughn, Columbus
- 10:00 **Pediatrics and General Practice Joint Section**
(ALL PHYSICIANS INVITED)
Augusta Room, Bon Air Hotel
PRESIDING
C. M. Templeton, Augusta
- 10:00 ALLERGY IN CHILDREN—A PHILOSOPHY OF MANAGEMENT
Victor C. Vaughan, III, Augusta
- 10:30 WOOD-TICK PARALYSIS (MOVIE AND COMMENT)
Frank Anderson, Augusta
- 11:45 **General Session Lectureship**
(ALL PHYSICIANS INVITED)
Crystal Room, Bon Air Hotel
- 12:00 ABNER CALHOUN MEMORIAL LECTURESHIP
PRESIDING
J. Willis Hurst, Atlanta
CARDIOVASCULAR DISEASE IN THE LIGHT OF THE LONG FOLLOW-UP
Paul Dudley White, Boston, Massachusetts

TUESDAY AFTERNOON, MAY 19

Social Events

(Not a part of Official Program)

Tuesday Afternoon, May 19

NOTE: Make reservations in advance with chairman if possible.

- 1:00 Georgia Diabetes Association Luncheon
Oglethorpe Lounge, Bon Air Hotel
Nathan DeVaughn, Augusta, Chairman
- 1:00 Georgia Chapter, American College of Surgeons Luncheon
Press Room, Bon Air Hotel
Gordon M. Kelley, Augusta, Chairman
- 1:00 Georgia Association of Pathology Luncheon
Chinese Room, Bon Air Hotel
E. V. Hastings, Augusta, Chairman
- 1:30 Georgia Academy of General Practice and Georgia State Obstetrical and Gynecological Society Luncheon
Crystal Room, Bon Air Hotel
C. M. Templeton and John T. Persall, Augusta, Co-chairmen

2:30 Obstetrics and Gynecology and General Practice Joint Section

(ALL PHYSICIANS INVITED)

Crystal Room, Bon Air Hotel

PRESIDING

Eugene Griffin, Atlanta

2:30 PANEL: TUMORS OF THE OVARY

MODERATOR:

Eugene Griffin, Atlanta

PANELISTS:

Robert Greenblatt, Augusta
Edgar Pund, Augusta
Iverson Bryans, Augusta
John F. Dillon, Houston, Texas
Lawrence Hester, Jr., Charleston, S. C.

2:30 Pathology Section

(ALL PHYSICIANS INVITED)

Augusta Room, Bon Air Hotel

PRESIDING

E. V. Hastings, Augusta

2:30 CLINICOPATHOLOGIC CORRECTION OF NEVI, JUVENILE MELANOMAS AND MALIGNANT MELANOMAS

Arthur Allen, Miami, Florida

3:20 SYMPOSIUM ELECTROPHORESIS

W. G. Rice, Augusta and G. R. Cooper, Atlanta

4:00 STATISTICAL EVALUATION OF DEATH CERTIFICATES AND AUTOPSY DIAGNOSIS

Hans J. Peters, Augusta

WEDNESDAY MORNING, MAY 20

9:00 House of Delegates Second Meeting (Recessed)

Crystal Room, Bon Air Hotel

PRESIDING

Thomas W. Goodwin, Augusta,
Speaker of the House

ORDER OF BUSINESS

(See *Delegates Handbook*)

11:30 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)

Crystal Room, Bon Air Hotel

PRESIDING

Lee Howard, Sr., Savannah, President,
Medical Association of Georgia

PRESENTATION OF 50 YEAR CERTIFICATES

Luther H. Wolff, Columbus, President-Elect

PRESENTATION OF HARDMAN AWARD

Mr. Lamartine C. Hardman, Commerce

PRESENTATION OF MAG CERTIFICATES OF APPRECIATION

Chris J. McLoughlin, Atlanta,
Secretary and Treasurer

PRESENTATION OF SCIENTIFIC EXHIBIT AWARDS

Ted F. Leigh, Atlanta, Chairman, Scientific
Exhibit Awards Committee

PRESENTATION OF MAG DISTINGUISHED SERVICE AWARD

Lee Howard, Sr., Savannah, President

PRESENTATION OF GOLF AWARDS

Joseph Mulherin, Augusta, Chairman,
Golf Awards Committee

SELECTION OF 1960 ANNUAL MEETING SITE

ANNOUNCEMENT OF MAG ELECTION RESULTS

Chairman, Tellers Committee

INSTALLATION OF 1959-60 OFFICERS

ADJOURNMENT OF *105TH ANNUAL SESSION

Woman's Auxiliary to the Medical Association of Georgia 34th Annual Meeting

May 17-20, 1959 — Augusta

President's Invitation

MEMBERS OF THE WOMAN'S AUXILIARY to the Medical Association of Georgia, it is my privilege to extend to each of you a cordial invitation to attend the Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia, to be held in Augusta May 17-20, 1959.

An enlightening, inspiring and entertaining program has been planned for your pleasure and participation!

Mrs. Luther H. Wolff

President, Woman's Auxiliary to the Medical Association of Georgia



Mrs. Luther H. Wolff



Mrs. F. N. Harrison

Welcome to Augusta

TO THE MEMBERS of the Woman's Auxiliary to the Medical Association of Georgia:

The Woman's Auxiliary to the Richmond County Medical Society wishes to extend to you a most cordial invitation to attend the 34th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

Entertainment has been planned for your pleasure and we hope your visit to Augusta will be an enjoyable one.

Sincerely,

Mrs. F. N. Harrison

President, Woman's Auxiliary to the Richmond County Medical Society

SUNDAY, MAY 17

11:00 Registration

to
5:00 Lobby, Bon Air Hotel

1:00 Pre-Convention Executive Board Meeting—Dutch Luncheon

(For 1958-59 officers, state chairmen, district managers, county presidents, county presidents-elect, past state presidents, and councilor to SMA Auxiliary)

Golf Room, Bon Air Hotel

PRESIDING

Mrs. Luther H. Wolff, Columbus, President

INVOCATION

Mrs. W. G. Elliott, Cuthbert

PLEDGE OF LOYALTY

Mrs. Lee Howard, Sr., Savannah

BUSINESS SESSION

5:00 Joint Meeting—MAG House of Delegates and Woman's Auxiliary

Crystal Room, Bon Air Hotel

PRESIDING

Thomas W. Goodwin, Augusta,
Speaker of the House

ORDER OF BUSINESS (See MAG Delegate's Handbook)

AUXILIARY PRESIDENT'S REPORT

Mrs. Luther H. Wolff, Columbus

8:30 General Session (G. P. Night)

Crystal Room, Bon Air Hotel

AN ADDRESS

Honorable S. Ernest Vandiver,
Governor, State of Georgia

MONDAY, MAY 18

8:30 Registration

to
3:30 Lobby, Bon Air Hotel

9:30 General Meeting

Partridge Inn

CALL TO ORDER

Mrs. Luther H. Wolff, Columbus, President

INVOCATION

Rev. Robert C. Daniel, Pastor, Crawford
Avenue Baptist Church

PLEDGE OF LOYALTY

Mrs. Bruce Schaefer, Toccoa

WELCOME

Mrs. F. N. Harrison, Augusta, President,
Woman's Auxiliary to the Richmond
County Medical Society

RESPONSE

Mrs. Ted Leigh, Atlanta, President,
Woman's Auxiliary to the Fulton
County Medical Society

INTRODUCTION OF HONOR GUESTS AND

PAST STATE PRESIDENTS

Mrs. Robert C. Major, Augusta

PRESENTATION OF CONVENTION PLANS

Mrs. L. Quinby Hair, Augusta,
General Chairman

INTRODUCTION OF PAGES FOR THE DAY

Mrs. Theodore Everett, Augusta, Chairman

REPORT OF ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY TO MAG

Virgil Williams, M.D., Griffin, Chairman

GREETINGS

Lee Howard, Sr., M.D., Savannah,
President, MAG

Luther H. Wolff, M.D., Columbus,
President-elect, MAG

INTRODUCTION OF GUEST SPEAKER

Mrs. Eustace Allen, Atlanta, Past President,
Woman's Auxiliary to the American
Medical Association

ADDRESS

Mrs. E. Arthur Underwood, Vancouver,
Washington, President, Woman's
Auxiliary to the American Medical
Association

Business Session

CONVENTION RULES OF ORDER

Mrs. Shelly C. Davis, Atlanta,
Parliamentarian

ROLL CALL

MINUTES

Mrs. Ennis W. Waldemayer, Americus,
Secretary

REPORTS

PRESIDENT

Mrs. Luther H. Wolff, Columbus

PRESIDENT-ELECT

Mrs. Remer Y. Clark, Marietta

TREASURER (Including report of Auditor)

Mrs. Hayward S. Phillips, Augusta

ADDENDUM REPORTS

COMPLETE REPORTS (See 1958-1959 Annual Report)

RECOMMENDATIONS OF EXECUTIVE BOARD

REVISIONS

Mrs. E. P. Inglis, Marietta, Chairman

REPORT OF CREDENTIALS COMMITTEE

Mrs. C. H. Watson, Augusta, Chairman

MEMORIAL SERVICE

Mrs. John B. Bowen, Augusta, Chairman

ANNOUNCEMENTS

ADJOURNMENT

12:30 Dutch Luncheon

(For past presidents of the Woman's Auxiliary to MAG)

2219 Overton Road

PRESIDING

Mrs. John E. Elliott, Savannah, Immediate Past President

12:30 Dutch Luncheon

(For county presidents, presidents-elect, district managers, district managers-elect, state chairmen, and officers)

Red Lion Grill, 1934 Walton Way

PRESIDING

Mrs. Remer Y. Clark, Marietta, President-elect

3:00 Historical and Garden Tour of to Augusta (air conditioned buses leave 5:00 front entrance of Bon Air Hotel at 3:00 p.m.)

Old Government House, 432 Telfair St.

RECEIVING AT TEA

Mrs. F. N. Harrison, Augusta, President,
Richmond County Auxiliary
Mrs. Luther H. Wolff, Columbus, President,
Woman's Auxiliary to MAG
Mrs. Arthur E. Underwood, Vancouver,
Washington, President, Woman's
Auxiliary to AMA
Mrs. George W. Owen, Jackson, Mississippi,
President, Woman's Auxiliary to
Southern Medical Association
Mrs. Remer Y. Clark, Marietta, President-
Elect, Woman's Auxiliary to MAG
Mrs. Lee Howard, Sr., Savannah,
Wife of MAG President
Mrs. L. Quinby Hair, Augusta, General
Chairman of Convention
Mrs. Joseph M. Echols, Augusta,
Chairman of Tea

TUESDAY, MAY 19

9:00 Registration

to
12:00 Lobby, Bon Air Hotel

9:30 General Meeting

Partridge Inn

CALL TO ORDER

Mrs. Luther H. Wolff, Columbus, President

INVOCATION

The Rev. Harvey L. Huntley, Pastor, Lutheran
Church of the Resurrection

PLEDGE OF LOYALTY

Mrs. Ralph Fowler, Marietta

INTRODUCTION OF PAGES FOR THE DAY

Mrs. Theodore Everett, Augusta, Chairman

ANNOUNCEMENT OF CONVENTION PLANS

Mrs. L. Quinby Hair, Augusta,
General Chairman

INTRODUCTION OF GUEST SPEAKER

Mrs. Stephen L. Brown, Augusta, Councilor
to Woman's Auxiliary to Southern
Medical Association

ADDRESS

Mrs. George W. Owen, Jackson, Mississippi,
President, Woman's Auxiliary to Southern
Medical Association

Business Session

ROLL CALL AND MINUTES

Mrs. Ennis W. Waldemayer, Americus,
Secretary

REPORT OF REVISIONS COMMITTEE

Mrs. E. P. Inglis, Marietta, Chairman

REPORT OF BUDGET AND FINANCE COM- MITTEE

Mrs. Ralph H. Chaney, Augusta, Chairman

REPORT OF RESOLUTIONS COMMITTEE

Mrs. A. H. Center, Savannah, Chairman

REPORT OF CREDENTIALS COMMITTEE

Mrs. C. H. Watson, Augusta, Chairman

REPORT OF COURTESY COMMITTEE

Mrs. W. Lynn Hicks, Macon, Chairman

REPORT OF AWARDS COMMITTEES

Achievement

Mrs. E. M. Dunstan, Decatur, Chairman
Doctor's Day

Mrs. L. G. Cacchioli, Hartwell, Chairman
Mrs. J. Bonar White Scrapbook

Mrs. Neal F. Yeomans, Waycross,
Chairman

Marie F. Burns Safety

Mrs. Douglas L. Head, Jr., Thomaston,
Chairman

Brawner Trophy for General Excellence

Mrs. John L. Elliott, Savannah, Chairman

REPORT OF NOMINATING COMMITTEE

Mrs. Walker L. Curtis, College Park,
Chairman

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS

Mrs. Shelly C. Davis, Atlanta, Past President
and Parliamentarian

PRESENTATION OF PRESIDENT'S PIN AND GAVEL

Mrs. Luther H. Wolff, Columbus
Retiring President

INAUGURAL ADDRESS AND ANNOUNCEMENT OF 1959-1960 CHAIRMEN

Mrs. Remer Y. Clark, Marietta, President

ANNOUNCEMENTS

ADJOURNMENT

12:30 Luncheon and Fashion Show by Davison-Paxon Company
(For All Auxiliary Convention Members)
Old Medical College, Sixth and Telfair Sts.
PRESIDING
Mrs. Luther H. Wolff, Retiring President

WEDNESDAY, MAY 20

9:00 Post Convention Executive Board Meeting—Dutch Breakfast
(For 1959-60 officers, chairmen, district managers, county presidents, county presidents-elect, past state presidents and councilor to SMA Auxiliary)

Press Room, Bon Air Hotel

PRESIDING
Mrs. Remer Y. Clark, President

11:30 Joint General Business Session
(All MAG and Auxiliary Members and Guests)

Crystal Room, Bon Air Hotel

PRESIDING
Lee Howard, Sr., Savannah,
President, MAG

PRESENTATION OF 50 YEAR CERTIFICATES
Luther H. Wolff, Columbus, President-elect

PRESENTATION OF HARDMAN AWARD
Mr. Lamartine C. Hardman, Commerce

PRESENTATION OF CERTIFICATES OF APPRECIATION
Chris J. McLoughlin, Atlanta,
Secretary-Treasurer, MAG

PRESENTATION OF SCIENTIFIC EXHIBIT AWARDS
Ted F. Leigh, Atlanta, Chairman, Scientific Awards Committee

PRESENTATION OF MAG DISTINGUISHED SERVICE AWARD
Lee Howard, Sr., Savannah, President

PRESENTATION OF GOLF AWARDS
SELECTION OF 1960 ANNUAL MEETING SITE

ANNOUNCEMENT OF ELECTION RETURNS
Chairman, Tellers Committee

INSTALLATION OF 1959-60 MAG OFFICERS

ADJOURNMENT OF *105TH ANNUAL SESSION

NOTE: Tickets are available at Ticket Desk for Auxiliary Convention Members for the Tour and Tea on Monday and the Luncheon and Fashion Show on Tuesday.

Register at Ticket Desk for transportation.

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
 2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
 3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
 4. Badges must be worn by members of the voting body during all general sessions of the convention.
 5. Delegates' privileges are not transferable.
 6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by the persons making and seconding the motion.
 7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
 8. All persons appearing on the program must be seated near the platform when the session opens.
- Whispering greatly retards the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

ORGANIZATION

of the

Woman's Auxiliary to the Medical Association of Georgia

Officers, 1958-1959

President—Mrs. Luther H. Wolff.....Columbus
President-Elect—Mrs. Remer Y. Clark.....Marietta
First Vice-President—Mrs. A. Hamblin Letton.....Atlanta
Second Vice-President—Mrs. Louie H. Griffin.....Claxton
Third Vice-President—Mrs. Neal F. Yeomans.....Waycross
Corresponding Secretary—Mrs. Luther Roberts.....Columbus
Recording Secretary—Mrs. Ennis W. Waldemayer.....Americus
Treasurer—Mrs. Hayward S. Phillips.....Augusta
Historian—Mrs. W. P. Stoner.....Sylvester
Parliamentarian—Mrs. Shelly C. Davis.....Atlanta

Advisory Committee

Virgil Williams, *Chairman*.....Griffin
W. G. Elliott.....Cuthbert
W. Bruce Shaefer.....Toccoa
Lee Howard, Sr., *ex-officio*.....Savannah
Luther H. Wolff, *ex-officio*.....Columbus

Committee Chairmen

Achievement Award—Mrs. Edgar M. Dunstan.....Decatur
Archives—Mrs. A. Worth Hobby.....Atlanta
American Medical Education Foundation—Mrs. T. E. DuPree.....Atlanta
Brawner Trophy—Mrs. John L. Elliott.....Savannah
Budget and Finance—Mrs. Ralph Chaney, Sr.....Augusta
Bulletin—Mrs. Frederick H. Thompson.....Atlanta
By-Laws and Procedures Revisions—Mrs. E. P. Inglis.....Marietta
Civil Defense—Mrs. George R. Dillinger.....Thomasville
Doctor's Day—Mrs. L. G. Cacchioli.....Hartwell
Editorial (Auxiliary News)—Mrs. Evert A. Bancker.....Atlanta
Legislation—Mrs. Virgil Williams.....Griffin
Mental Health—Mrs. Charles R. Smith.....Columbus
Organization—Mrs. Remer Y. Clark.....Marietta
Program—Mrs. A. Hamblin Letton.....Atlanta
Public Relations—Mrs. Thomas H. Williams.....Macon
Recruitment—Mrs. John E. Porter.....Savannah
Research in Romance of Medicine—Mrs. C. James Roper.....Jasper
Safety—Mrs. Douglas L. Head, Jr.....Thomaston
Scrapbook—Mrs. Neal F. Yeomans.....Waycross
Student Loan Fund—Mrs. W. L. Sheppard.....Augusta
Today's Health—Mrs. Louie H. Griffin.....Claxton
State Handbook—Mrs. Robert C. Major.....Augusta

District Managers

First—Mrs. David Robinson.....Savannah
Second—Mrs. W. P. Stoner.....Sylvester
Third—Mrs. Maurice Arnold.....Hawkinsville
Fourth—Mrs. Robert E. Dallas.....Thomaston
Fifth—Mrs. Howard Lee.....Decatur
Sixth—Mrs. Milford B. Hatcher.....Macon
Seventh—Mrs. Remer Y. Clark.....Marietta
Eighth—Mrs. Byron Davis.....Valdosta
Ninth—Mrs. Arthur M. Hendrix.....Canton
Tenth—Mrs. Ralph Wenzel.....Social Circle

Councilor, Woman's Auxiliary to the Southern Medical Association

Mrs. Stephen W. Brown.....Augusta

County Auxiliary Presidents

Baldwin (Putnam)—Mrs. R. W. Bradford.....Milledgeville
Bibb (Crawford, Jones, Monroe, Twiggs, Wilkinson)—
Mrs. W. Lynn Hicks.....Macon
Bullock (Candler, Evans)—Mrs. R. L. Pence.....Metter
Carroll, Douglas, Haralson—Mrs. E. V. Patrick.....Carrollton
Chatham (Bryan, Liberty, Long, Effingham, McIntosh)—
Mrs. A. H. Center.....Savannah
Chattahoochee (Gwinnet-Forsyth)—
Mrs. Rupert H. Bramblett.....Cumming

Chattooga—Mrs. H. A. Goodwin.....Summerville
Cherokee-Pickens—Mrs. Ben K. Looper.....Canton
Cobb—Mrs. W. C. Mitchell.....Smyrna
Coffee—Mrs. E. D. Bell.....Douglas
Decatur-Seminole—Mrs. E. M. Griffin.....Bainbridge
DeKalb—Mrs. Floyd R. Sanders, Jr.....Decatur
Dougherty—Mrs. Albert S. Trulock, Jr.....Albany
Elbert-Franklin-Hart—Mrs. Carey Mickel, Jr.....Elberton
Flint (Crisp, Turner, Dooley)—Mrs. Perry Busbee.....Cordele
Floyd—Mrs. Tom Harbin.....Rome
Fulton—Mrs. Ted Leigh.....Atlanta
Glynn—Mrs. Frank Mitchell.....Brunswick
Gordon—Mrs. Bill Purcell.....Calhoun
Habersham-Towns-White—Mrs. Fletcher O. Garrison.....Demorest
Hall-Lumpkin—Mrs. Hamil Murray.....Gainesville
Jackson-Barrow—Mrs. C. B. Skelton.....Winder
Muscogee—Mrs. Walter Thwaite.....Columbus
Ocmulgee (Bleckley, Dodge, Pulaski, Wilcox)—

Mrs. W. E. Coleman.....Hawkinsville
Polk-Paulding—Mrs. Charles M. Smith.....Rockmart
Randolph-Terrell (Stewart-Quitman)—Mrs. R. B. Martin III.....Cuthbert
Richmond (Columbia)—Mrs. F. N. Harrison.....Augusta
South Georgia (Lowndes, Lanier, Berrien, Cook, Clinch)—

Mrs. S. H. Story, Jr.....Valdosta
Southwest Georgia (Calhoun, Early, Miller, Baker, Clay)—

Mrs. Jack Standifer.....Blakely
Spalding (Butts, Lamar, Henry, Pike)—

Mrs. J. W. Landham, Jr.....Griffin
Sumter-Schley-Macon-Marion—Mrs. Schley Gatewood.....Americus
Thomas-Brooks—Mrs. George Dillinger.....Thomasville
Tift—Mrs. Robley D. Smith.....Tifton
Troup (Heard)—Mrs. Pierre Herault.....LaGrange
Upson—Mrs. R. E. Dallas.....Thomaston
Ware (Bacon, Brantley, Camden, Charlton, Jeff Davis, Pierce)—

Mrs. W. B. Bates, Jr.....Waycross
Walker-Catoosa-Dade—Mrs. Charles Stephenson.....Ringgold
Washington—Mrs. F. T. McElreath, Jr.....Tennille
Wayne—Mrs. Robert A. Pumpelly.....Jessup
Whitfield-Murray—Mrs. George C. Kerr.....Dalton
Worth—Mrs. H. G. Davis, Jr.....Sylvester

Past Presidents and Conventions

Honorary Presidents for Life

Mrs. James N. Brawner, Sr., Atlanta
Mrs. Eustace A. Allen, Atlanta

1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta,
Temporary Chairman

1925—Atlanta—Mrs. James N. Brawner, Sr., Atlanta

1926—Albany—Mrs. William H. Myers, Savannah

1927—Atlanta—Mrs. C. W. Roberts, Atlanta

1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore, Gaffney, S. C.)

1929—Macon—Mrs. Charles C. Hinton, Macon

1930—Augusta—Mrs. Marion T. Benson, Atlanta

1931—Macon—Mrs. Charles C. Harrold, Macon

1932—Savannah—Mrs. Ralston Lattimore, Savannah

1933—Macon—Mrs. S. T. R. Revell, Louisville

1934—Augusta—Mrs. J. Bonar White, Atlanta (Deceased)

1935—Atlanta—Mrs. J. E. Penland, Waycross

1936—Savannah—Mrs. Ernest R. Harris, Winder

1937—Macon—Mrs. W. R. Dancy, Savannah

1938—Augusta—Mrs. Ralph Chaney, Augusta

1939—Atlanta—Mrs. Warren A. Coleman, Eastman

1940—Savannah—Mrs. Eustace A. Allen, Atlanta

1941—Macon—Mrs. H. G. Bannister, Ila

1942—Augusta—Mrs. Lee Howard, Savannah

1943—Atlanta—Mrs. J. Lon King, Macon

1944—Savannah—Mrs. Olin S. Cofer, Atlanta

1945—No convention

1946—Macon—Mrs. W. T. Randolph, Winder

1947—Augusta—Mrs. W. Bruce Schaefer, Toccoa

1948—Atlanta—Mrs. W. G. Elliott, Cuthbert

1949—Savannah—Mrs. S. A. Anderson, Atlanta

1950—Macon—Mrs. J. Harry Rogers, Atlanta

1951—Augusta—Mrs. Lehman W. Williams, Savannah

1952—Atlanta—Mrs. J. R. S. Mays, Macon

1953—Savannah—Mrs. Ralph Fowler, Marietta

1954—Macon—Mrs. Leo Smith, Waycross

1955—Augusta—Mrs. Shelley C. Davis, Atlanta

1956—Atlanta—Mrs. Robert C. Major, Augusta

1957—Savannah—Mrs. Walker L. Curtis, College Park

1958—Macon—Mrs. John L. Elliott, Savannah

Convention Committees

WOMAN'S AUXILIARY TO THE RICHMOND COUNTY MEDICAL SOCIETY

General Chairman

Mrs. L. Quinby Hair

Advisory Committee

Mrs. Robert C. Major
Mrs. Walter L. Sheppard

Credentials and Registration

Mrs. C. H. Watson, *Chairman*
Mrs. C. A. Burgamy, *Co-Chairman*
Mrs. D. E. Tanner
Mrs. A. W. Miller
Mrs. C. Stephen Mulherin
Mrs. C. B. Shiver
Mrs. Theo Thevaos
Mrs. W. G. Watson
Mrs. Jack Bell
Mrs. Henry W. Bailey
Mrs. Alfred M. Battey
Mrs. J. Malcolm Bazemore
Mrs. Augustin S. Carswell
Mrs. W. N. Agostas
Mrs. Alex T. Murphey
Mrs. Harry B. O'Rear
Mrs. W. R. Voyles
Mrs. A. L. Humphries
Mrs. John Kemble
Mrs. Thomas W. Goodwin
Mrs. Maurice Dunn
Mrs. Charles W. Hock
Mrs. John M. Miller
Mrs. Corbett H. Thigpen
Mrs. W. Eugene Matthews
Mrs. Joseph L. Mulherin
Mrs. Thomas E. Bailey
Mrs. James H. Butler
Mrs. Claude E. Tessier
Mrs. Robert C. Major
Mrs. Walter L. Sheppard

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Mrs. Stephen W. Brown, *Chairman*
Mrs. David C. Williams
Mrs. Stewart Flanagan
Mrs. Harry T. Harper, Jr.

Display and Meeting Rooms

Mrs. William S. Boyd, *Chairman*
Mrs. James W. Bennett
Mrs. G. Frank Jones
Mrs. Joseph Akerman
Mrs. Curtis H. Carter
Mrs. Hayward S. Phillips
Mrs. Claude M. Burpee

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Mrs. Harold S. Engler
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Mrs. Thomas L. Clary, Jr., *Co-Chairman*
Mrs. Julius Johnson
Mrs. W. J. Williams
Mrs. C. Conrad Smith
Mrs. J. Robert Rinker
Mrs. C. Martin Rhode
Mrs. W. W. Battey

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Mrs. C. M. Templeton
Mrs. Harry Pinson
Mrs. Henry R. Perkins
Mrs. F. Lansing Lee
Mrs. Robert G. Ellison
Mrs. John M. Martin
Mrs. Nathan DeVaughn
Mrs. Jack H. Levy
Mrs. William F. Hamilton, Jr.
Mrs. Ben Moss
Mrs. E. B. Kissam

Fashion Show

Mrs. Pierce G. Blich, Jr., *Chairman*
Mrs. Louis L. Battey

Luncheon

Mrs. Charles Freeman, Jr., *Chairman*
Mrs. J. Alfred Green
Mrs. James Bryans
Mrs. James D. Grant
Mrs. George H. Kinser
Mrs. C. P. Avato
Mrs. Preston Ellington
Mrs. Mason H. Shepherd
Mrs. Stuart H. Prather, Jr.
Mrs. S. T. Hutchison

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Mrs. Sherman L. Allis
Mrs. Lester L. Bowles
Mrs. Ira Goldberg
Mrs. Edwin C. Jungck
Mrs. Joseph L. Caldwell, Jr.
Mrs. Robert E. McCall
Mrs. Edwin L. Rushia
Mrs. William E. Barfield
Mrs. S. K. Brown
Mrs. Thomas J. Howard
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Mrs. J. Fred Denton
Mrs. James L. Sawyer

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Mrs. W. D. Jennings, Jr., *Chairman*
Mrs. A. Jack Waters
Mrs. Charles M. Mulherin

Printing and Favors

Mrs. Cecil A. White, *Chairman*
Mrs. Jack Hudson, *Co-Chairman*
Mrs. Charles G. Luther
Mrs. Bithel Wall

Past Presidents' Luncheon

Mrs. Robert C. Major, *Chairman*
Mrs. Ralph H. Chaney, Sr.

County Presidents' Luncheon

Mrs. Gordon M. Kelly, *Chairman*
Mrs. M. B. Sell, *Co-Chairman*
Mrs. J. W. Thurmond
Mrs. C. J. Shealy

Tea

Mrs. Joseph M. Echols, *Chairman*
Mrs. Julius T. Rucker, Jr.
Mrs. James B. Kay, Jr.
Mrs. C. Goodrich Henry
Mrs. F. G. Stephens
Mrs. Frank Anderson
Mrs. William A. Steed
Mrs. Samuel Holmstock
Mrs. E. S. Sanderson

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Mrs. Pomeroy Nichols, Jr., *Chairman*
Mrs. E. Val Hastings, *Co-Chairman*
Mrs. Julius T. Rucker, Jr.
Mrs. John T. Manter
Mrs. E. K. McLain
Mrs. Rufus F. Payne
Mrs. Thomas Findley
Mrs. Robert Greenblatt
Mrs. James Bryans
Mrs. George F. McInnes
Mrs. M. Preston Agee
Mrs. Robert R. McKnight
Mrs. David R. Thomas
Mrs. James Kemp
Mrs. Herman Peskins
Mrs. Henry Scoggins
Mrs. F. X. Mulherin
Mrs. Leonard R. Massengale

Social Hour and Banquet

Mrs. Charles I. Bryans, *Chairman*
Mrs. G. Lombard Kelly
Mrs. Jay Herbert West
Mrs. Robert C. McGahee
Mrs. Menard Ihnen

Memorial Service

Mrs. John B. Bowen, Augusta, *Chairman*
Mrs. W. O. White, Jr., Augusta
Mrs. Hayward S. Phillips, Augusta

Courtesy

Mrs. Lynn Hicks, Macon, *Chairman*
Mrs. R. E. Dallas, Thomaston
Mrs. Arthur M. Hendrix, Canton

Tellers

Mrs. Albert S. Trulock, Jr., Albany
Mrs. R. W. Bradford, Milledgeville
Mrs. E. V. Patrick, Carrollton
Mrs. Frank Mitchell, Brunswick

Timekeepers

Mrs. Schley Gatewood, Americus
Mrs. W. B. Bates, Jr., Waycross
Mrs. H. G. Davis, Jr., Sylvester
Mrs. S. H. Storey, Jr., Valdosta

Reading

Mrs. W. C. Mitchell, Smyrna, *Chairman*
Mrs. Howard Lee, Decatur
Mrs. Ralph Wenzel, Social Circle
Mrs. Bryan Davis, Valdosta

Resolutions

Mrs. A. H. Center, Savannah, *Chairman*
Mrs. Maurice Arnold, Hawkinsville
Mrs. Ben K. Looper, Canton
Mrs. Tom Harbin, Rome
Mrs. Milford B. Hatcher, Macon

Awards

Achievement

Mrs. E. M. Dunstan, Decatur, *Chairman*
Mrs. Leo Smith, Waycross
Mrs. Virgil B. Williams, Griffin

Brawner Trophy (General Excellence)

Mrs. John L. Elliott, Savannah, *Chairman*
Mrs. Walker Curtis, College Park
Mrs. Robert C. Major, Augusta

Doctor's Day

Mrs. L. G. Cacchioli, Hartwell, *Chairman*
Mrs. W. G. Elliott, Cuthbert
Mrs. J. W. Landham, Jr., Griffin

Mrs. J. Bonar White Scrapbook

Mrs. Neal F. Yeomans, Waycross, *Chairman*
Mrs. Louie H. Griffin, Claxton
Mrs. A. Hamblin Letton, Atlanta

Safety

Mrs. Douglas L. Head, Jr., Thomaston, *Chairman*
Mrs. Floyd R. Sanders, Jr., Decatur
Mrs. Ralph Fowler, Marietta
Mrs. Walter Thwaite, Columbus
Mrs. John E. Porter, Savannah

Pledge of Loyalty to the

Woman's Auxiliary to the Medical Association of Georgia

I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of Georgia. I will support its activities, protect its reputation, and ever sustain its high ideals.

Collect

"Keep us, O God, from pettiness; let us be large in thought, word and deed. Let us be done with fault-finding, and leave off self-seeking. May we put away pretense, and meet each other face to face, without self-pity and without prejudice.

May we never be hasty in judgment, and always generous. Let us take time for all things; make us to grow calm, serene, gentle.

Teach us to put into action our better impulses, straightforward and unafraid. Grant that we may realize it is the little things that create differences; but in the big things of life we are one.

And, may we strive to reach and to know the great, common woman's heart of us all, and O, Lord God, let us not forget to be kind."

"Ek? Oh, I never go!"

*says Dr. J.M. Smart, H. & B.D.**

**(Horse and Buggy Doctor)*



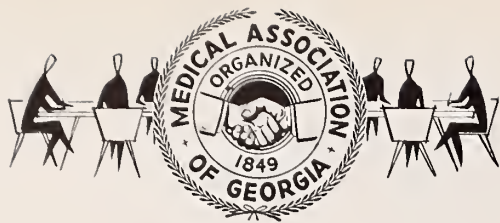
Don't Be An H. & B. D.

(Horse and Buggy Doctor)

Attend the Annual Session of

The Medical Association of Georgia

May 17-20, Augusta, Georgia



the association

ANNOUNCEMENTS

The American College of Chest Physicians will hold its Silver Anniversary meeting at the Ambassador Hotel, Atlantic City, June, 3-7. Examinations for Fellowship in the College will be held on June 4. It is expected that a number of physicians from other countries will attend the 25th Annual Meeting.

The 24th Annual Congress of the North American Federation, International College of Surgeons, will be held in Chicago, September 13-17. The federation is composed of the United States, Canadian, Mexican, and Central American Sections. Write: Secretariat, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Ill.

Seventh Bahamas Medical Conference will be held March 30 until April 11 at the British Colonial Hotel, Nassau, Bahamas. American and Canadian citizens do not require passports. Vaccination certificates are not now required. For further information, write: Dr. B. L. Frank, Organizing Physician, Bahamas Conferences, P. O. Box 4037, Fort Lauderdale, Fla.

The Association of American Physicians and Surgeons will hold its 16th Annual Meeting of the Assembly and Delegates at Fort Worth, Texas at the Hilton Hotel, April 2-4. All physicians who are members of their county medical societies are eligible to attend the sessions, and are cordially invited to do so, whether or not they are members of AAPS.

SOCIETIES

A panel discussion featuring "Cardiac Emergencies in the Operating Room" was the highlight of the recent meeting of THE GEORGIA MEDICAL SOCIETY. Jules Victor was the moderator of the panel which included Ellison R. Cook, III, internal medicine; Thomas Freeman, surgery; and George Pastorius, anaesthesiology.

Virgil S. Steele, Eastman, has been elected president of the OCMULGEE MEDICAL SOCIETY. Other officers for the ensuing year are: Harold Conner, Eastman, vice-president; Reid Gullatt, Cochran, secretary-treasurer; William Coleman, Hawkinsville, delegate; and Maurice Arnold, Hawkinsville, alternate. President Steele has appointed the following to serve as program committee for the year: Frank Holder, Eastman; Gus Batts, Hawkinsville; and Richard Smith, Cochran.

Dr and Mrs. Carter Meadows entertained the WAYNE COUNTY MEDICAL ASSOCIATION and their wives at dinner recently at the Bon Air Restaurant.

Edward Dorney of the Department of Medicine at Emory University recently gave a talk before the WHITFIELD COUNTY MEDICAL SOCIETY entitled "Bedside Diagnosis of Cardiac Arrhythmias."

THE SOUTH WEST GEORGIA MEDICAL SOCIETY voted recently to make Jack G. Standifer of Blakely a life member since he has passed his 70th birthday and has been in active practice in excess of 47 years.

DEATHS

FRAY OWEN PEARSON, 55, of Macon died unexpectedly January 9. Dr. Pearson was medical director for the central region of the Georgia Department of Public Health, and also was a director of the State Health Department.

Dr. Pearson was a native of Tennessee and attended schools in Tennessee. He was graduated from Vanderbilt Medical College and Johns Hopkins. He attended the Church of Christ and had been a resident of Macon for the past six years, coming from Chattanooga, Tenn.

Survivors include his wife; two sons, William D. Pearson and Perry O. Pearson, Macon; and his mother, Mrs. W. T. Pearson, Nashville, Tenn.

PERSONALS

First District

L. M. FREEDMAN of Savannah has been elected president of the Physicians Service Association by the Board of Directors.

THOMAS A. AMBURGEY, Savannah orthopedic surgeon, has been named medical director of the Clair Henderson Memorial Center.

Second District

No news submitted.

Third District

E. F. SEAY of Ft. Valley has been named chief of the medical staff at the newly opened Peach County Hospital.

J. C. SERRATO, JR., of Columbus recently met with the Georgia Association of Plaintiffs Trial Attorneys, Inc.

WILLIAM R. ANDERSON, Americus, has been elected president of the medical staff of the Americus and Sumter County Hospital. R. A. COLLINS, JR., Americus, was elected vice-president; and WILLIAM B. McMATH, Americus, was re-elected secretary.

At a recent meeting of the Columbus Lay Diabetic Society, JOHN K. DAVIDSON of Columbus made a report on his trip to the American Diabetes Association in St. Louis.

Recently, LEONARD T. MAHOLICK, Columbus, delivered the keynote address at a three-day workshop on Community Mental Health Centers held in Topeka, Kansas.

The Montezuma Kiwanis Club installed LANGDON C. CHEVES as their president for 1959.

FRANK A. WILSON, III, Leslie, was appointed to the Board of Trustees of Union High School by the Sumter County Board of Education.

Because of his many services, A. G. HENDRICK, Perry, was named by the Perry Kiwanis Club as the "Man of the Year" for this community in 1958.

Fourth District

AUGUSTUS H. FRYE, JR. has returned to Griffin to resume his medical practice there after completing a three year training period at the Baroness Erlanger Hospital in Chattanooga.

Fifth District

JAMES E. ANTHONY, JR., of Decatur was certified by the American Board of Surgery in December.

JOHN RHODES HAVERTY has passed the specialty boards examinations and is now a Licensiate of the American Board of Pediatrics.

At a recent meeting of the Cobb County Medical Society, WALTER L. BLOOM of Atlanta was guest speaker.

EUGENE C. KANE, formerly of St. Simons' Island, has announced the opening of his office in the Medical Arts Building in Atlanta.

At a post-graduate course in fractures which is part of the continuing education program of the Medical College of Georgia, WOOD W. LOVELL, Atlanta, was a guest lecturer.

WALTER L. BLOOM, Atlanta, was a speaker at the 55th Annual Congress on Medical Education and Licensure held in Chicago.

R. BRUCE LOGUE, Atlanta, recently gave a talk before the Chattanooga Academy of Surgery.

WALTER L. BLOOM, Atlanta, spoke at the Southeastern Conference on Better Foods for Better Nutrition held in Athens.

Recently two talks before a meeting of the East Tennessee Heart Association in Knoxville were given by R. BRUCE LOGUE of Atlanta.

VERNELLE FOX, medical director of the Georgian Clinic and Commission on Alcoholism, has been named

Atlanta's 1958 Woman of the Year in the Professions.

RICHARD W. BLUMBERG, professor of pediatrics in Emory School of Medicine was named director of professional services at Eggleston Hospital in Atlanta.

JOHN T. LESLIE of Decatur was installed as 1959 president of the Decatur Kiwanis Club.

MURDOCK S. EQUEN of Atlanta, and ROBERT L. BROWN, EDGAR F. FINCHER, TED F. LEIGH, and JOHN D. MARTIN of Emory University took part in the three-day sectional meeting of the American College of Surgeons in Charleston, S. C.

R. BRUCE LOGUE was recently elected Chairman of the Sub-specialty Board in Cardiology of the American Board of Internal Medicine.

Sixth District

J. F. O'DANIEL has been named chief of staff of the Laurens County Hospital. He succeeds ROBERT T. ANDERSON. FRED J. COLEMAN, former chief of staff, was elected secretary of the group.

THOMAS L. ROSS of Macon was a guest speaker at the Dublin branch of the Georgia Heart Association.

Macon Hospital's new medical staff officers have been named for the coming year. The officers include W. D. HAZLEHURST, chief medical staff officer; E. C. McMILLAN, JR., vice chief of staff; THOMAS HARROLD, president; J. S. MAYS, vice president; JOHN THOMAS DUPREE, secretary; and WILLARD R. GOLSAN, parliamentarian.

Seventh District

GEORGE B. SMITH of Rome has retired from active practice.

Eighth District

W. F. REAVIS, who has practiced medicine in Waycross and Homerville for nearly half a century, has retired from active practice.

Ninth District

No news submitted.

Tenth District

WILLIAM F. HAMILTON of the Medical College of Georgia was presented with the Gold Heart Award of the American Heart Association at a luncheon given in his honor at the Richmond Hotel in Augusta.

After 46 years of practice, A. S. JOHNSON, SR., Elberton, has retired.

WILLIAM R. MORETZ of Augusta took part in the three-day sectional meeting of the American College of Surgeons in Charleston, S. C.

At the southeastern regional meeting of the International College of Surgeons in Miami, GEORGE W. SMITH of Augusta was a program participant.

C. H. THIGPEN and FRANK P. ANDERSON of Augusta took part in a recent meeting of the Georgia Chapter of the American Physical Therapy Association.

MASON H. SHEPHERD has announced the opening of his office for the practice of general surgery at the Medical Arts Building in Augusta.

RURAL HEALTH COMMITTEE MEETING, Feb. 1, 1959

THE MEDICAL ASSOCIATION OF GEORGIA RURAL HEALTH Committee was called to order at 11:15 A.M., Sunday, February 1, 1959 in Conference Room E, Georgia Education Center, Athens, Georgia by Chairman Albert Morris.

Members of the Committee present included Albert L. Morris, Chairman, Fairburn; Charles McArthur, Cordele; and Hugh B. Cason, Warrenton. Members of the Advisory Committee included Miss Lucile Higginbotham and Mr. William A. King. Also present was Mr. H. G. Steed, State Department of Health and Mr. M. D. Krueger, MAG Executive Secretary.

Chairman Morris called on Mr. Krueger to read the minutes of the Rural Health Committee meeting of October 26, 1958 and these minutes were approved as corrected clarifying the reference to "health records, cards and pamphlets" to be written as "family health records, individual health cards and pamphlets."

MOVIE FILM LIBRARY—Chairman Morris presented Miss Higginbotham with certain movie picture films requested from the AMA by Dr. Morris for a proposed movie film library to be used in the state of Georgia. Dr. Morris stated that Miss Higginbotham would be in charge of this health film library and that records would be kept of the use of these films in their showing to groups in the state of Georgia.

HEALTH INSURANCE PAMPHLET—Chairman Morris and the Committee revised a rough draft of a proposed insurance pamphlet titled "About Health Insurance for You and Your Family." After discussion, this pamphlet was revised by the Chairman and members of the Committee and on motion (McArthur-Cason) it was voted that the revised version of this pamphlet be printed by the Medical Association of Georgia for distribution to rural families by Miss Higginbotham and for distribution to the physicians in active practice in the state of Georgia by the Association.

HOSPITAL-MINISTERIAL SURVEY—Chairman Morris called on Mr. Krueger to report for Dr. Katrine Hawkins who had made an extensive survey of the hospitals in Georgia having 15 beds or over on the subject of chaplin service in these hospitals. Mr. Krueger reported that 166 questionnaires had been sent to hospital administrators of the Georgia hospitals of 15 beds or over and that 74 responses to the questionnaire were received, thus giving a percentage of response of 44 per cent. The committee studied the results from the questionnaire and on motion (Morris-McArthur) it was voted to aid and assist the special association committee on Ministerial Liaison and the Rev. E. A. Driscoll in activity in this field. It was further voted to commend Dr. Katrine Hawkins for the meaningful information presented in the survey.

PARAMEDICAL RECRUITMENT—Chairman Morris called on Mr. Krueger who reported on the activity of the Public Service Committee in this field. After discussion on motion duly made and seconded it was voted to augment the Public Service Committee's activity by asking Mr. H. C. Steed to compile a list of types of training and locations of training schools and centers in Georgia for para-medical personnel. It was recommended that this list be used to augment materials and booklets now under consideration by the Association Public Service Committee.

HOME SAFETY AND POISON CONTROL CENTERS—Chairman Morris called on Mr. H. C. Steed who explained the activity and the function of the State Department of Health in accident prevention and the progress to date in the poison control program. Mr. Steed discussed the establishment of certain poison control centers over the state of Georgia and then discussed the Grady Hospital problem in connection with a poison control center at that institution. It was recommended that Dr. Morris work with the Fulton County Medical Society Committee appointed to study the problem of a poison control center at Grady Hospital and that Dr. Morris also contact Dr. Hackney, Fulton County Health Department Director to ascertain what progress can be made in the establishment of a poison control center in Atlanta.

On motion (McArthur-Morris) it was voted to wholeheartedly support and endorse the poison control center program of information, treatment, prevention, research and education as outlined by Mr. Steed. The plan outlined by Mr. Steed envisages the establishment regional poison information centers in certain strategic areas of the state. While the plan originally calls for five such centers, Mr. Steed stated that there would be an optimum of approximately 13 such centers which would provide information to physicians on a 24 hour basis. On motion duly made and seconded, it was voted that the Rural Health Committee should present this project to the Association House of Delegates meeting May 17, 1959 for Association support, approval and endorsement.

GEORGIA HEALTH RECORD FORM—Chairman Morris called on Dr. Charles McArthur, Cordele, who had designed a physical examination sheet to be filled in by the family physician of 4-H Club members, Boy Scouts, Safety Patrol and campers in connection with their application for summer encampments. Dr. McArthur reported that such a physical examination sheet had been prepared and was presented to the 4-H Club authorities, Boy Scouts, Safety Patrol, etc. On motion duly made and seconded, it was recommended that the Committee present this physical examination sheet to the Association House of Delegates for approval and endorsement to be used in the state of Georgia for the purposes of insuring health standards in summer encampments.

Chairman Morris called for new business and there being none the meeting was adjourned at 4:30 P.M. It was generally agreed that the next meeting of the Committee would be held at the discretion of the Chairman.

WEEKLY HEALTH COLUMN COMMITTEE MEETING, Jan. 28, 1959

THE MEETING OF THE MAG WEEKLY HEALTH COLUMN Committee was called to order Wednesday, January 28, 1959 at the MAG Headquarters Office, Academy of Medicine, Atlanta, at 7:15 by Chairman H. C. Derrick, Jr., LaFayette.

Present, in addition to Chairman Derrick, were August C. Yochem, Atlanta; E. P. Inglis, Marietta; Lamar F. Glass, Atlanta; Jule P. Neal, Macon; Mrs. Bob Christian, Atlanta; and Mr. John Kiser and Mrs. Emily Grinalds of the Headquarters Office Staff.

The following articles were read and APPROVED for release:

1. Simple Croup No Cause for Alarm
2. Surgery Best Treatment for Ruptures
3. Watch Those Tranquilizers
4. Painless Sleep Grows Safer

Chairman Derrick read a letter from the American Cancer Society, Georgia Division. Mr. Ed Bridges, Director of Professional Education, Patient Services, commended all of the DOC MAG Columns, and stated that he was particularly gratified to read the column on Cancer recently published in the Weekly Health Column.

Chairman Derrick told the Committee of a telephone call from Dr. C. J. Wyatt, Jr., Rome, stating that due to illness in his family, he thought it best to resign from the Weekly Health Column Committee. The Committee voted not to accept Dr. Wyatt's resignation, and instructed Mr. Kiser to write him of the valuable contribution he has made to the Committee. Dr. Derrick stated that another internist would be contacted to assist Dr. Wyatt.

On January 17, 1959 a letter was sent to the editors of all weekly papers in Georgia requesting them to suggest topics for the Weekly Health Column that would be of particular interest to their localities. The following articles were suggested to date:

Frostbite Treatment
More Articles on Cancer
Stomach Ulcers
Diabetics
Bronchial Troubles
Sinus Troubles
Mental Health
Diet in Regard to Heart Condition
Care of the Ears
New Drugs for Mental Disturbances

Vaccines for Colds
Why Have a Family Physician?
Georgia's Biggest Health Problems
Leukemia
Pink Eye
Problems of the Aged
How to Prevent Heart Attacks
Series Advising Proper Eye Examination

New articles to be APPROVED at the next meeting:

1. Kidney Stones (Glass)
2. Shock Treatments (Yochem)
3. Breast Feeding (Neal)
4. Adopting a Baby (Neal)
5. The Joys of Smoking (Inglis)
6. Boils (Derrick)
7. Worms (Inglis)

Articles for DISCUSSION at the next meeting are as follows:

- Crawford W. Long Day (Christian)
Cancer of Breast (Glass)
Cancer of Cervix (Neal)
Care Problems of the Aged (Derrick)
Mental Sickness (Yochem)

It was suggested that the various kinds of cysts be used as articles for DOC MAG.

It was voted that the next meeting of the Weekly Health Column Committee be held on February 18, 1959 at 7:00 P.M., Headquarters Office, Academy of Medicine, Atlanta.

There being no further business, the meeting was adjourned at 9:15 P.M.

Be sure and get a
glimpse of

AUGUSTA

site of
the *105th Annual Session
In this issue.

THE MONTH IN WASHINGTON

CONTRARY TO THE USUAL procedure in a first session, the 86th Congress this year already is getting on with its work, particularly in health fields. In past Congresses, not much is accomplished the first session, with most bills held over to the second, which always is an election year.

The session was only weeks old when action was under way. Here are some of the developments, portending enactment before adjournment of a number of bills:

1. After hearings, a subcommittee of the Senate Banking and Currency Committee reported favorably on a housing bill that contained provision for mortgage guarantees for proprietary nursing homes. Subsequently, the measure was passed by the Senate.

At this writing the House is at work on another housing bill that also contains the nursing home loan section. With House passage assumed, the question is whether the bill (containing more money than the White House wants spent) will be vetoed, and if vetoed whether it can be enacted anyway by two-thirds majorities in both houses.

2. Without bothering with hearings, the House Ways and Means Committee overwhelmingly approved the Keogh bill to encourage retirement plans for the self-employment. It acted in line with the committee's established procedure to quickly reapprove bills that passed the House the previous Congress, but not the Senate. The Keogh bill is identical with a measure that easily cleared the House last session but lost out in the Senate.

3. Driven forward by Chairman Carl Vinson of the House Armed Services Committee, legislation to extend the regular and doctor drafts four years rolled through the House. However, indications were the Senate would take its time and give careful consideration to the need for a four-year extension.

4. The Senate Labor and Welfare Committee, under the leadership of Chairman Lister Hill (D., Ala), demonstrated its interest in legislation for the aged. Senator Hill named a subcommittee to make a full year's study of problems of the aged, taking in housing, employment and recreation, as well as medical aspects.

Chairman of this subcommittee is Senator Pat McNamara, Detroit Democrat. Other Democrats are Senators John Kennedy of Massachusetts, Joseph Clark of Pennsylvania, and Jennings Randolph of West Virginia. Republicans are Senators Everett Dirksen of Illinois and Barry Goldwater of Arizona.

5. At the same time, three members of the standing health subcommittee of the Hill Committee, Senators Jacob K. Javits of New York, Clifford B. Case of New Jersey, and John Sherman Cooper, all Republicans, asked Congress to authorize a two-year study of the health problems of the entire population. If approved by Congress, the investigation would look into the quality and quantity of health services, problems of extending health insurance, special problems of the aged and minority groups, and the distribution of health services.

1959

Annual Session

AUGUSTA • MAY 17-20, 1959 • BON AIR HOTEL

Guest Speakers

Pathologist—Arthur Allen, Miami, Florida

Surgeon—Curtis P. Artz, Jackson, Mississippi

Pediatrician—Louis K. Diamond, Boston, Massachusetts

Radiologist—John A. Evans, New York, New York

Internal Medicine—Edgar A. Hines, Rochester, Minnesota

Anesthetist—M. Digby Leigh, Los Angeles, California

Radiology—Mr. William Ramey, Rochester, New York

Anesthetist—George J. Thomas, Pittsburgh, Pennsylvania

Cardiovascular Disease—Paul Dudley White, Boston, Massachusetts
(Calhoun Lectureship)

AMA President-elect—Lewis M. Orr, Orlando, Florida

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THE USE OF ALPHA-CHYMOTRYPSIN IN CATARACT SURGERY

Morgan B. Raiford, M.D., D.Sc. (Med.), *Atlanta*

This new agent shows great promise as an adjunct in ophthalmic surgery

THE FIRST RECORDED use of alpha-chymotrypsin was reported by Jenkins¹ in June, 1955 in an effort to try to dissolve vitreous opacities in the eye of a 35 year old man who had previously had no vision. Two injections and withdrawals were made in the vitreous chambers of the eye and about 10 minutes after the second injection, the lens freed itself and floated free in the anterior chamber which necessi-

tated removal of the lens. The first cataract done by Jenkins was in August, 1955 and he used 1-1000 solution of alpha-chymotrypsin. The present Chymar[®]¹ solution that he is using is a 1-5000 solution for all cases.² From 1955 to 1958, in a series of 27 cataract operations ranging in age from five to 82, he has found no untoward secondary complications which could be attributed to the use of alpha-chymotrypsin. Further, he has periodically checked these patients for a thinning of the hyaloid mem-

(1) Chymar; alpha-chymotrypsin manufactured by the Armour Pharmaceutical Co. of Kankakee, Illinois.

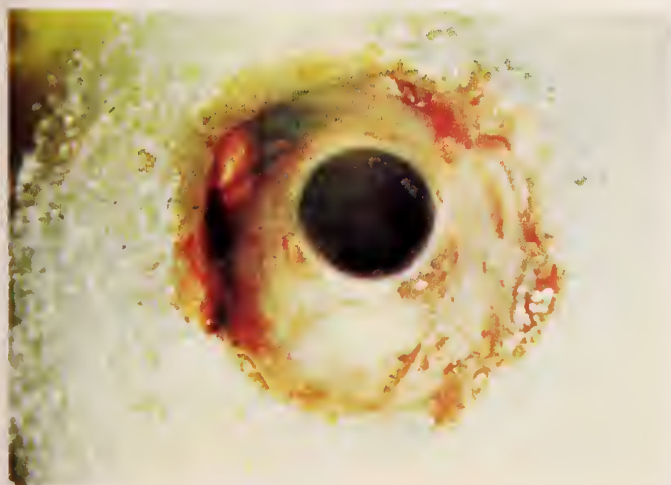


Figure 1: Cornea and iris excised showing lens and zonules intact.

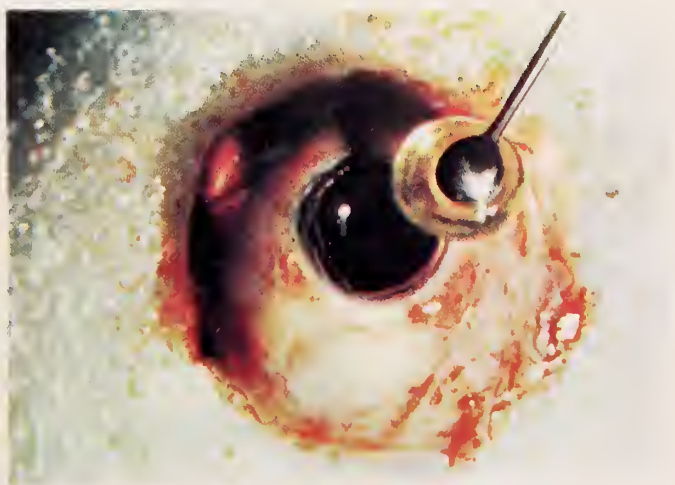


Figure 2: Removal of lens by erisiphake. Enzymatic zonulolysis was complete by the use of Chymar 1-10,000 solution.



Figure 3: Pressure on globe causing hyaloid to protrude. No evidence of action upon the hyaloid was revealed by this test.

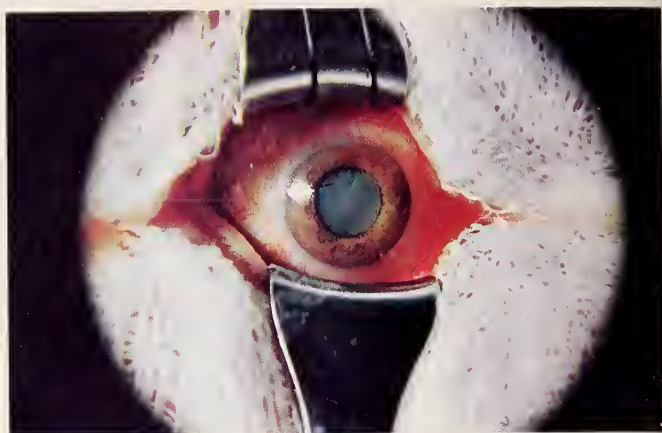


Figure 4: Cataract lens with pupil dilated and the No. 4-0 silk fixation suture placed in the insertion of the superior rectus muscle.

CATARACT SURGERY / Raiford

brane or any type of residual or complicating effect.

Barraquer³ reported the use of alpha-chymotrypsin by endeavoring to clear up a massive vitreous hemorrhage on May 28, 1957. After three days the lens luxated into the vitreous. From experimentation in rabbit eyes, Barraquer could not find any positive conclusion in respect to the alpha-chymotrypsin upon the zonular fibers. This was because of the difference in the structure between the zonular fibers of the rabbit and the human. However, he found that no great damage was evident to the eye on gross and microscopic anatomical examination.

In the second series of experimentation, Barraquer evaluated the use of alpha-chymotrypsin in the eyes from humans which had been removed six hours after death. The first two cases used a 1-1000 solution and within 12 hours a complete luxation of the lens was present. Following experiments with

1-30,000 solution, little effect was found on the zonule fibers. Rutllan⁴ and Barraquer's technique is now 1-5000 to 1-10,000 in physiological saline solution in a series of 10 cases with good results. After approximately two minutes elapses, they have found that the lens would bulge forward and appear more superficial and shaky. The lens was readily removed with the erisiphake technique. No changes were found in the cornea, iris, hyaloid, or vitreous in these cases.

Chemical Characteristics and Actions

Alpha-chymotrypsin is absolved from the pancreas as chymotrypsin, purified and crystallized in a white powder. It is put in vials of 2mg. each. In the Chymar solution, a 10cc. vial of sterile isotonic salt solution is used as a diluent and will make a 1-10,000 solution.

In a series of 11 cases I have used the chymotrypsin of Laboratorio P.E.V.Y.A. of Barcelona, Spain. In my subsequent 26 cases, I have used the

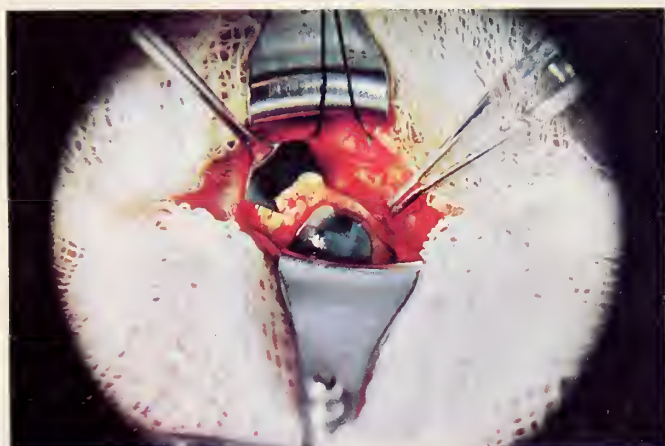


Figure 4A: Conjunctival flap has been made and reflected over tip of keratome. Incision is then enlarged by scissors.

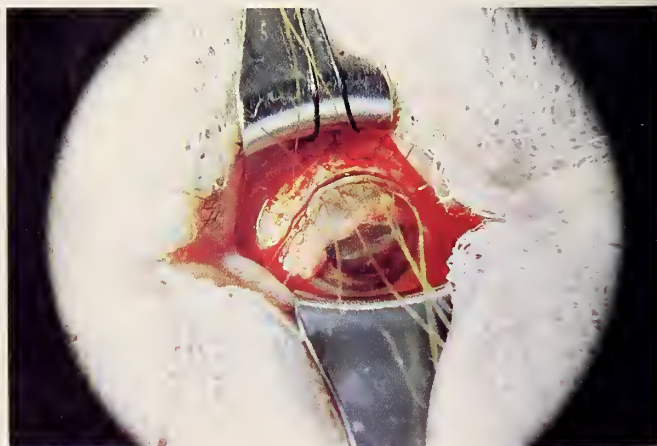


Figure 5: Corneo-scleral sutures are taken with No. 6-0 chromic cat gut. Conjunctiva is reflected forward.

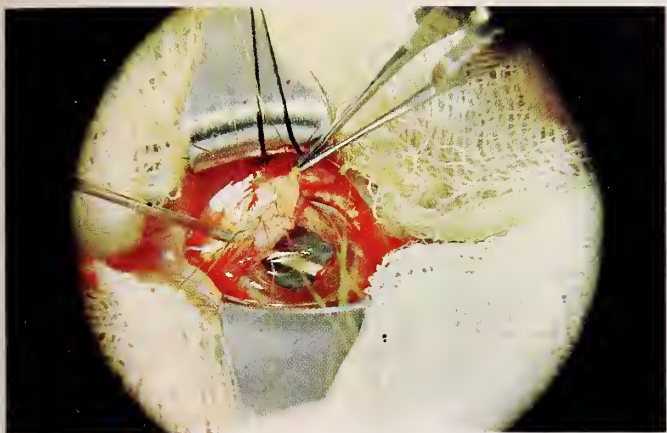


Figure 6: Alpha-chymotrypsin is being irrigated into the anterior and posterior chambers in the eye. 5cc. of a 1-10,000 solution is usually used. The tip is placed under the iris border to insure irrigation of the posterior chamber.

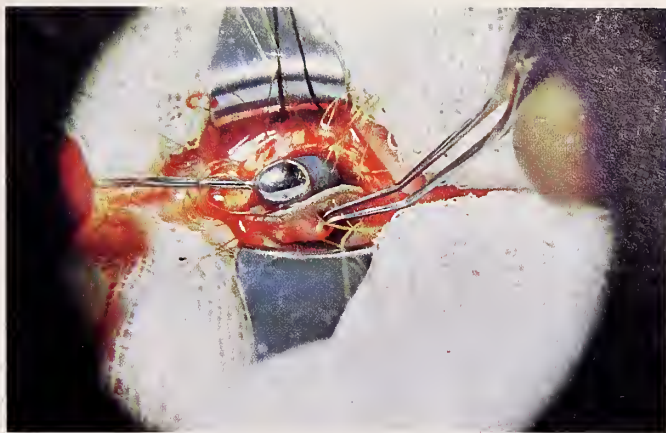


Figure 7: Erisiphake is withdrawing the lens, cornea being reflected by curved iris forceps.

alpha-chymotrypsin which was supplied by Armour Pharmaceutical Co. of Kankakee, Illinois.

The second and third cases, J.D., WF 71 and W.J. WM 36, had each had cataract surgery done previously with a resulting 20/20 and 20/15 vision with cataract lenses. These cases were done early in 1958 without the enzyme being used. A solution was used in all cases in which Quimotrase®² was employed. All cases have been followed with a slit lamp examination. The hyaloid membrane was thinner in cases one, two, and three in which Quimotrase® was employed. The cornea was edematous at the suture point in number four which was reversed by the second postoperative week by local hydrocortisone 0.25 ointment, applied locally b.i.d.

The 11 cases of cataract surgery in which Quimotrase® was employed took place from September

25, 1958 to December 20, 1958. Two to four cubic centimeters of the enzyme were used. The zonule fibers were loosened in two and one half to four minutes. Identical quantities of the Chymar® solution were used in the remaining cases with like results. Keeney⁷ reported the use of Chymar in a patient five years old. There was no adhering of the hyaloid to the lens in this case.

Present Technique

A conjunctival flap is made (Figure 4) following local anesthesia and 200-400 mg. of intravenous Sodium Nembutal® is used for anesthesia. Akinesia is obtained by localized injection of Xylocaine®. Six to eight preplaced corneo-scleral No. 6-0 sutures are taken (Figure 5). The alpha-chymotrypsin is then irrigated into the posterior chamber; 5cc. of the solution (1-10,000) is used and carefully irrigated into the posterior chamber (Figure 6) by an Amsler needle; and two peripheral iridectomies are then

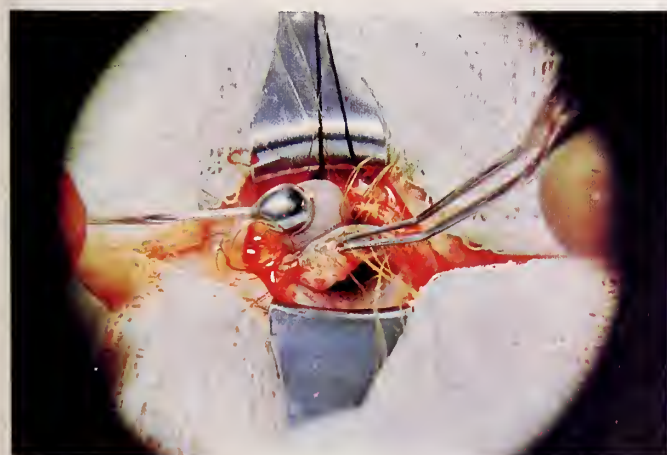


Figure 7A: Loose lens being brought forward by Erisiphake. No assistance required as the zonulolysis has been made completely by the use of alpha-chymotrypsin.

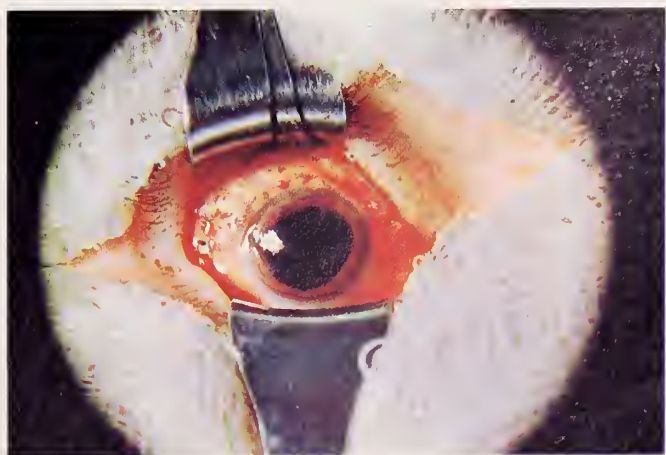


Figure 7B: All sutures, both corneo-scleral and conjunctival have been secured and showing photograph of eye immediately after removal of the cataract.

(2) Quimotrase; from the Laboratorio P.E.V.Y.A., Calle Verdaguera, 161, Molins de Rey, Barcelona, Spain.

CATARACT SURGERY / Raiford

made. The sutures are loosened and looped forward; three placed nasalward and the others temporalward looped by an iris spatula. A saline filled Bell erisiphake is then placed on the lens and the lens is brought forward by a sliding forward motion (Figure 7) and no other assistance is required. A period of three to four minutes has been found most effective for the zonulolysis to be affected if a 1-10,000 solution is used, slightly faster zonulolysis is obtained if a 1-5,000 solution is employed. Air is usually placed in the anterior chamber (nine of the 19 cases) after the lens is removed.

Results

1. In the 69 cases reported by Jenkins,² Keeney,⁷ Vidal,⁸ and myself, no untoward results have been found which could be attributed to the action of alpha-chymotrypsin on the eye.

2. There have been no direct actions upon the corneal structures observed under slit lamp microscopic examination which in some cases go back to 1956.

3. In three cases in which previous cataract surgery had been done without the use of the enzyme, the hyaloid face was thinned and bulged forward in comparison to its fellow eye in which the enzyme was used. All three of these cases employed a 1-5,000 solution of the Quimotrase.[®]

4. Edema of the cornea occurred in two cases which were reversed by hydrocortisone ointment b.i.d. for one week. I do not feel, however, that this may be attributed to the use of the α -chymotrypsin.

5. Seventeen of the cases are wearing contact lenses. This is advocated in preference to cataract glasses.

6. The visual acuity ranges from 20/15 to 20/30 vision with only one case having 20/60 vision in my series. Healing of the wound is not interfered with in any way. Twenty-three of the 69 cases had no measurable astigmatic correction. The greatest amount was 2.25 diopters, the average being 1.25 diopters.

7. The suture materials in my cases were six to eight corneo-scleral No. 6-0 chromic sutures and in Jenkins cases were No. 6-0 silk. The alpha-chymotrypsin in no way affected the suture material. In two cases, fragments of the chromic material were soaked in a 1-5,000 solution of the enzyme for 30 minutes without gross change in the suture or its tensile strength.

8. Saline solution was used to wash the enzyme

from the anterior and posterior chambers in all cases.

9. In one case, W.M. 17, the alpha-chymotrypsin had no effect on post-cataract membrane of traumatic origin.

Experimental Studies⁽³⁾

Motion picture films were taken of human eyes following removal of the corneal and iris structures. This illustrated the action of the Chymar[®] 1-10,000 solution directly on the zonule fibers. Dr. Ben Jenkins assisted in carrying out these experiments. These pictures show the influence enzymatic zonulolysis has upon the technique of cataract or lens removal. The zonule (Figure 1) is well intact and no negative effect by the Chymar[®] solution upon the hyaloid was demonstrated. This also collaborates the writer's findings on the 39 cases on clinical follow-up with slit lamp examinations. The removal of the luxated lens (Figure 2) is demonstrated. The hyaloid is protruding forward (Figure 3) showing no evidence of weakness following the enzyme usage.

Summary

1. The use of alpha-chymotrypsin in cataract surgery gives the ophthalmic surgeon a new and valuable adjunct in conducting surgical procedures.

2. The use of enzyme in children reduces the hazard of the needling operation. (However, good anesthesia in suturing the wound must be advantageously adhered to for best results.)

3. The removal of cataracts may be done with greater ease by the surgeon.⁴

4. The post-operative follow-up results have shown no impairment by alpha-chymotrypsin on the ocular structures.

The writer is indebted to Dr. Ben H. Jenkins for his assistance in conducting the experimental work of Chymar on human eyes and the direction of the motion pictures of these observations.

679 Juniper Street

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(3) Experimental Studies; Medical Research Department, Piedmont Hospital, Atlanta, Georgia, with the assistance of Dr. Walter Bloom, Director of Laboratories and Medical Research.

DISCUSSION OF NITROFURANS IN THE TREATMENT OF VAGINITIS

The agent used in these investigations is effective though in no sense a panacea.

AT A RECENT MEETING results with the use of the nitrofurans in 210 patients from our private practice were presented and discussed. At the onset of this study three observations pointed out to me the complexity of assessing the value of any therapeutic agent in the treatment of vaginitis. The first of these was that though a careful history fails to reveal any symptoms of vaginal discharge or irritation, *Trichomonas* and/or *Candida albicans* is often found in the vaginal secretions. The second was that in some clinics where *Candida* and *Trichomonas* infections are treated with acid douches only, on re-examination many will be free of symptoms and the organisms can no longer be found in vaginal secretions. The third observation occurred when one of the early antibiotics was being tested as an *in vivo* trichomonicide. The very early results in one group of patients seem to indicate a "cure rate" of over 90 per cent. When these patients were followed only three months, the cure rate had dropped to less than 30 per cent.

Drs. Frech and Lanier are to be commended for overcoming some of the above implied difficulty by careful exclusion of therapy other than that under investigation and their rigid criteria for cure and improvement.

I would like to present some of the results and conclusions in our analysis of the treatment of 210 patients with the nitrofurans. Of this total 122 had *Trichomonas vaginalis* vaginitis alone, 18 had *Candida albicans* alone, and 70 were infected by both.

C. Walter Coolidge, M.D.; C. Stedman Glisson, Jr., M.D.; and Arthur A. Smith, M.D., *Atlanta*

The ages of these patients ranged from six to 74 years and 13 per cent were pregnant. Forty-nine of these were treated with Furoxone® before the manufacturer added micofur to the product for its fungicidal properties. During the majority of our study, patients were examined for the infecting agent and insufflated with Tricofuron Powder® every two to three days until marked improvement was noted. The home treatment consisted of a daily cleansing douche and twice daily insertion of Tricofuron Suppositories.® Almost immediate symptomatic improvement was noted with the first insufflation. After the acute phase the suppositories were used once daily except during the menses when the initial therapy was resumed. Treatment was continued through two menstrual cycles. The patient was considered cured when symptom free and infecting organisms could not be found on repeated examinations during a three month period. Of the 161 patients treated with Tricofuron Improved,® 143 were thought cured, nine improved, and nine total failures. This would indicate a cure rate of 88.8 per cent which is surprisingly similar to the figure reported by Drs. Frech and Lanier.

Of these so called "cured" patients, 117 were followed from one to three years and 28 showed recurrences one or more times. These, I feel, are rightfully classed as recurrences rather than failure

Presented at the 104th Annual Session of the Medical Association of Georgia, April 29, 1958, Macon, Georgia.

of the therapeutic agent since there was absence of symptoms and organisms for three continuous months prior to reappearance.

All of the patients in this series had a catheter urine specimen examined for the infecting organisms. There were 28 cases which showed *Candida*, *Trichomonas*, or both in the bladder urine. These were treated with either Furadantin® or a tetracycline-nystatin combination. If prompt response of the bladder infection to this therapy was not obtained, the cooperation of a urologist was enlisted. The therapy of the urologist in these cases was directed toward eradication of foci of infection in the urethra and assuring adequate drainage of the bladder.

The enlistment of cooperation of the husband of the recurrently infected patient has been relatively unsuccessful. Even when the patient showed

complete relief during periods of abstinence and return of infection when relations were resumed, many of the men rebelled at the suggestion that this was a problem common to both marital partners.

Sensitivity to the product was noted in 2.4 per cent of the patients. One of the five sensitive patients in 210 gave a history of being sensitive to every therapeutic agent suggested for her treatment.

Treatment during the menses, measures to keep the vulva dry and measures to prevent contamination from the alimentary tract were stressed to our patients throughout the series.

The agent used in both our investigations is certainly a helpful, effective one, though not a panacea. Improvement of results in the treatment of the vaginitides will lie in better understanding and control of the modes of infection. A safe, specific, effective, oral medication for *Trichomonas* and *Candida* would certainly be a boon to all physicians who have women patients.

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The APAA held 21 Annual Art Exhibitions to date. The exhibitions have become an integral part of the annual AMA Conventions. Between 250 and 500 pieces of art were exhibited annually, and these received favorable and widespread newspaper and magazine publicity.

To further the art interest among physicians, APAA also issues descriptive catalogues, news-

letters, and stimulates local cultural meetings for physicians to exchange views and ideas in the field of art.

In addition, APAA is establishing a central, photographic archive of its members' art works, to be used for year-round press and magazine publicity in the physicians' home towns as well as nationally.

Types of membership:

Sponsor Membership	\$25
Regular Membership	\$10
Associate Membership	\$ 3

(for medical students, internes, residents)

Your APAA membership benefits include:

1. A membership diploma.
2. Free annual subscription to the APAA Newsletter.
3. Discounts on art books, text books, art materials.
4. Special magazine subscription rates.
5. Privilege to exhibit at the Annual Art Exhibition. Sponsor members receive, in addition to the above benefits, two free entries in the national exhibition.

Physicians who are interested in membership in this organization should write directly to: Dr. Ted F. Leigh, Emory University Clinic, Atlanta 22, Georgia.

GEORGIA CANCER REGISTRY PROGRAM

To date, registries have been begun in 18 state-aid clinics and four additional hospitals not in the state-aid program.

William R. Vogler, M.D.* and Robert L. Brown, M.D.,** *Atlanta*

IN 1955 THE COMMITTEE ON Cancer of the American College of Surgeons published a revised *Manual for Cancer Registries and Cancer Clinical Activities*,¹ listing the minimum requirements for approval of a cancer program. First they stated, "Cancer activity must be conducted either in and by the staff of a hospital approved by the Joint Commission on Accreditation of Hospitals, or in lieu of this by an organization, the cancer activities of which have the formal approval of the local county medical society." Three types of hospitals conducting cancer programs are recognized as eligible for accreditation: first, the specialized cancer hospital; second, the general hospital conducting organized cancer clinical activities; and third, the general hospital which maintains only a register of all its cancer patients. Each hospital must have a committee on cancer consisting of physicians interested in cancer who are willing to conduct the cancer program.

Since January 1, 1956 no hospital has been eligible for approval for cancer activities by the College of Surgeons unless a cancer registry is part of the cancer program. The registry consists of a listing of all patients with cancer diagnosed after a given date, abstracts of the patients' records, and a method for following the progress of each patient until death. Its purposes are:

1. To report to the staff annually their cancer salvage rate.
2. To record all cancer patients seen in a given institution after a specified date.
3. To have available a file of abstracts con-

taining diagnosis, treatment, and follow-up information for teaching, research, and reporting purposes.

4. To have a systematic method of obtaining regular follow-up information on all treated patients.

Thus the essential components of a registry must be the names and addresses of all patients with a cancer diagnosis, an abstract of each patient's record, and an annual follow-up note.

Subsequent to the announcement of the American College of Surgeons of the new requirements for approval of cancer activities, the Georgia Division of the American Cancer Society with the cooperation of the staff of the Robert Winship Memorial Clinic at Emory University and the National Cancer Institute, undertook the establishment of cancer registries in the state-aid cancer clinics throughout Georgia. These are clinics receiving state funds to assist in the care of indigent cancer patients. They are associated with hospitals in their communities. Correspondence with various registries over the country enabled us to review many forms, indexing procedures, and follow-up methods. The forms discussed below were finally adopted. They are printed by the Georgia Division of the American Cancer Society as a contribution to the Georgia Cancer Registry Program.

In January of 1956 the directors of the state-aid cancer clinics accepted the forms and procedures for general use. The Georgia Division of the American Cancer Society agreed to pay two dollars to each clinic for each newly diagnosed cancer entered in its registry. The Georgia State Health Department agreed to punch cards and tabulate the data for each clinic annually.

To date, registries have been started in 18 state-

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GEORGIA CANCER REGISTRY PROGRAM

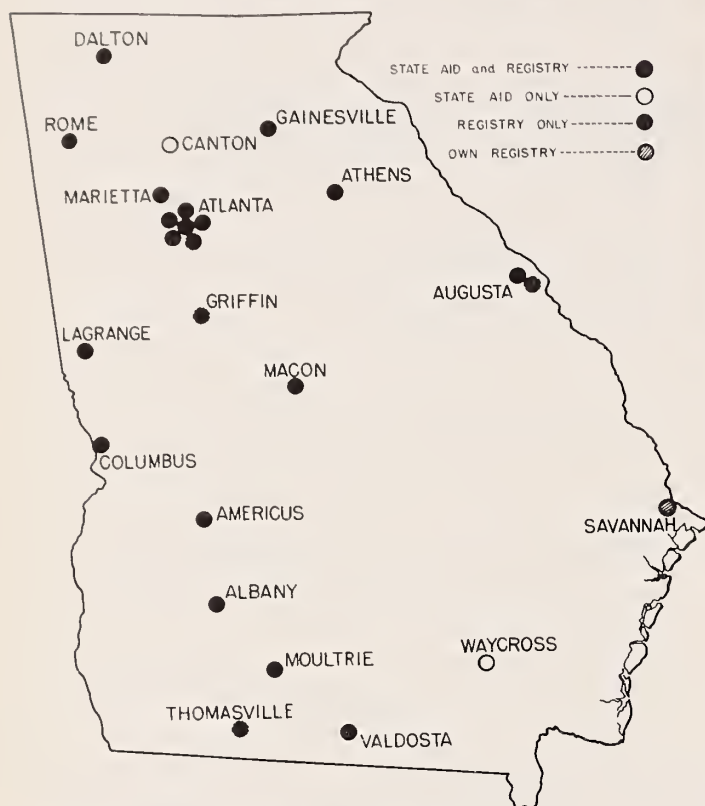


Figure 1: Georgia Cancer Registry Program.

aid clinics and four additional hospitals not in the state-aid program. These hospitals are distributed fairly evenly over the state (Figure 1). Each hospital does its own abstracting, coding, and follow-up. With the aid of a grant by the Georgia Division of the American Cancer Society, a secretary is employed who travels to the various hospitals to insure uniformity of coding. Every year each hospital sends its coded information to the State Health Department for processing. Reports are given to each hospital and a composite report of all the data is also prepared.

A brief description of the procedures and components of the registry follows. The first step in entering the patients in the registry is to obtain all charts bearing a diagnosis of cancer. This should include all patients, private and charity, with and without microscopic diagnoses, who have cancer. This can best be done through the record department and the departments of pathology and radiology in the hospital. Those records bearing a cancer diagnosis are set aside to be entered in the registry. Depending upon the institution, it may be necessary for carbons of pathology and X-ray reports to be forwarded to the registry secretary. It is better to enter the patient after the record is completed,

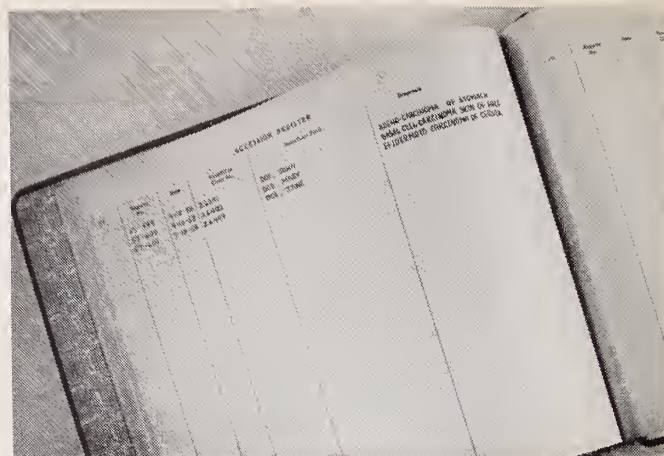


Figure 2: Accession Book.

that is, after all laboratory, X-ray, and pathology reports are on the record. In addition, some patients receive treatment over a six-week period and time should be allowed for its completion prior to entering the patient in the registry.

The components of the registry are the Accession Book, the Patient Index Card, the Abstract Card, and the Cancer Registry Code Sheet. Once the chart is made available to the secretary, the patient's name, chart number, and diagnosis are listed in the Accession Book (Figure 2). It is through the serial numbering of the Accession Book that an identifying registry number is assigned each patient. This registry number will appear on all forms completed on the individual patient. The record is abstracted, coded, and a colored tag for the month of follow-up placed on the Abstract Card (Figure 3). Using the *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death*, 1955 Revision, the Abstract Card is assigned to the primary site in which the cancer arose. The card is then placed in the permanent Abstract Card file. In this file, arranged numerically by ISC (International Statistical Classification) code numbers, the card is filed alphabetically within its primary site. Thus a diagnostic index file is established.

In addition, a Patient Index Card (Figure 4) is

ISC Code No.		Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.											
Name		Registry No.											
Address		Primary Site											
Date of Birth		Final Diagnosis											
Date of Death		Date of Admission											
Marital Status		Date of Discharge											
Hospital Number		Date of Referral											
Type of Patient		Date of Follow-up											
Previous treatment elsewhere for this cancer		Date of Treatment											
Treatment here (date and type)		Date of Referral											
Purpose of treatment		Date of Referral											
Name and address of physician or hospital responsible for follow-up		Date of Referral											
Date of Death		Date of Referral											
Cause of death		Date of Referral											
Remarks		Date of Referral											
CANCER REGISTRY MEDICAL RECORD ABSTRACT													
FOLLOW-UP DATA ON BACK OF THIS CARD													

Figure 3: Abstract Card.

Figure 4: Patient Index Card.

When a patient dies the Abstract Card is filed in an inactive file by the ISC code number. Code sheets are not returned to the Health Department when there is no additional information. Patients seen only in consultation are placed in the inactive file also, if they receive no treatment in the year after entry.

In Georgia we have attempted to provide an

Despite these efforts errors have arisen. One of the main reasons for error is the rather frequent change in personnel. It takes the average secretary with some background in medical terminology one to two months to become competent enough to handle most of the routine cases. Close supervision during this period is essential. Whenever several people are doing the same job, differences in interpretation and an increased number of errors occur.

L-450 American Cancer Society, Georgia Division, Atlanta 9, Ga.

Figure 5: Cancer Registry Code Sheet.

TUMOR REGISTRY
Department of Medical Records
Emory University Hospital
Emory University, Georgia

[illegible]

Re:

Dear

We are bringing our records up to date in connection with our Tumor Registry and would like to have any of the following information that you might be able to give us in regard to the above named patient. Our last contact was

Please check

<input type="checkbox"/> Dead	Date of death _____
<input type="checkbox"/> Cause of death	
<input type="checkbox"/> Cancer	Primary site _____
<input type="checkbox"/> <input type="checkbox"/> local recurrence	
<input type="checkbox"/> <input type="checkbox"/> metastasis	
<input type="checkbox"/> <input type="checkbox"/> unknown	
<input type="checkbox"/> Other	
<input type="checkbox"/> <input type="checkbox"/> specify _____	
<input type="checkbox"/> <input type="checkbox"/> unknown	
<input type="checkbox"/> Alive	Date of last contact _____
<input type="checkbox"/> <input type="checkbox"/> with cancer	
<input type="checkbox"/> <input type="checkbox"/> local recurrence	
<input type="checkbox"/> <input type="checkbox"/> metastasis	
<input type="checkbox"/> <input type="checkbox"/> unknown	
<input type="checkbox"/> <input type="checkbox"/> without cancer	

Remarks (List any additional treatment):

Please return in the enclosed stamped envelope.

Sincerely,

Tumor Registry Secretary

The success of this endeavor is reflected by the fact that 18 of the 21 clinics in the State Aid Cancer Program have established registries in the first two years. In addition, four other hospitals have become part of the registry program. It should be stressed that the success of any local registry depends primarily upon the interest of the physicians in that hospital.

Summary and Conclusions

P. O. Box 459

Reference

1. Manual for Cancer Registries and Cancer Activities—by the Committee on Cancer—American College of Surgeons—1955.

100% CONTRIBUTORS

DeKalb County Medical Society . .	\$338.00
Dougherty County Medical Society .	210.00
Emanuel County Medical Society .	25.00
Floyd County Medical Society . . .	265.00
Gordon County Medical Society . .	40.00
Jackson-Barrow Co. Medical Society	65.00
Jefferson County Medical Society . .	40.00

Jenkins County Medical Society . .	15.00
Oconee County Medical Society . .	10.00
Peach Belt County Medical Society .	85.00
Polk County Medical Society . . .	45.00
South Ga. County Medical Society .	215.00
Southwest Ga. County Medical Society	50.00
Southeast County Medical Society .	85.00
Troup County Medical Society . .	200.00
Walker-Catoosa-Dade	125.00
Whitfield County Medical Society .	115.00
Wilkes County Medical Society . .	35.00

DIAGNOSTIC AND THERAPEUTIC NERVE BLOCKS

This basically simple diagnostic and therapeutic tool has proven its worth in situations where the diagnosis is obscure and where other forms of therapy have been ineffective.

George P. Whitelaw, M.D., *Boston, Massachusetts*

THIS SUBJECT IS ONE of interest to the general practitioner, internist and surgeon alike. Each one frequently encounters problems that might be successfully treated by the utilization of procaine injection. In certain instances, temporary alleviation of symptoms by such methods may point toward more definitive surgical measures and, in this way, the therapeutic use of procaine is inevitably closely linked with its *diagnostic* use. However, we will limit this discussion to therapy insofar as possible.

Traditionally, surgeons and anesthesiologists have performed these maneuvers. The more complicated procedures should obviously be limited to experienced hands. Nevertheless, there is no reason why internists and general practitioners should not become skilled in their use. For the most part, these injections can be carried out in the office.

During the past three years, we have performed approximately 400 injections of various kinds, both in the office and in the hospital, and approximately 75 per cent have been in relation to the stellate or lumbar sympathetic ganglia. Though procaine blocks are applied more generally to portions of the sympathetic nervous system, other indications for blocking maneuvers have arisen, as will be apparent in the discussion which follows.

Safeguards in the Use of Blocking Agents

Although, in our own experience, we have been fortunate in not encountering a major catastrophe following any blocking procedure, we have this possibility constantly in mind and take every precaution to avoid adverse reactions. Potential dangers exist with injection therapy because of the introduction of the needle itself and because of the reaction to the drug used. Even in the most experienced hands, certain reactions may occur to block-

ing procedures with any drug. The more alarming of these are (1) blood vessel injection, (2) pneumothorax, and (3) subarachnoid injection. We have had one partial pneumothorax due to introduction of the needle into the pleura during a stellate block, and three cases of unilateral recurrent laryngeal nerve paralysis.

Several reactions have occurred to the procaine itself. Adriani, Parmley, and Ochsner¹ state that reactions to procaine may be of two varieties, depressive and convulsive, and that barbiturates are helpful in avoiding the convulsive type of reaction. We have had no instances of convulsive type but have had several depressive reactions with dizziness, lowering of blood pressure and rapid pulse. While Adriani et al. do not feel that barbiturates are helpful in avoiding the depressive reaction, we routinely use 120 mg. (two grains) of Luminal Sodium[®] subcutaneously prior to any injection in which more than 5 cc. of procaine is to be used. Since this routine has been adopted, the reaction to procaine has practically disappeared. We are now using one per cent xylocaine more frequently and feel there are less reactions to this agent.

Because of the potential danger of subarachnoid injection, Rovenstine² advocates that a kit containing the usual resuscitative agents be close at hand when any block is performed. We agree with this advice. Though not completely infallible in avoiding such a calamity, frequent aspirations should be made to determine whether or not the needle tip is in the subarachnoid space when near the intervertebral foramen. This routine should always be observed to avoid the introduction of procaine into a blood vessel as well.

As Adriani et al.¹ have mentioned, an excellent way to determine whether the needle point has been introduced into the pleura is to place a drop or two of the blocking agent into the hub of the needle

Presented at the 104th Annual Session of the Medical Association of Georgia, April 29, 1958, Macon, Georgia.

when disconnecting the syringe. If the patient takes a deep breath, the fluid will either rapidly disappear or be rapidly expelled. This is not infallible either but should be observed when introducing needles near the pleura.

Stellate Ganglion Block

Because of its anatomical relationship to the sympathetic nerve supply of the head, neck, and upper extremities, the stellate ganglion is the most important structure to be considered in the overall use of blocking procedures. Further emphasis has been placed on the importance of this structure since a book, encompassing it as the sole subject, has been published by Moore.³

As in all portions of the sympathetic nervous system, anatomical variation can occur. Martinez¹ made a special study of the stellate ganglion in this respect and found it may migrate slightly superiorly or inferiorly. Having observed the anatomical position of this ganglion on somewhat over 300 different occasions, it is our impression this structure is one of the least variable of all the ganglia. It lies directly anterior to the inner aspect of the first rib near its articulation with the transverse process of the first thoracic vertebra. It is a large structure and may reach a length of 2 cm. The stellate ganglion is a result of fusion of the inferior cervical and first thoracic ganglia and is one single structure of varying shapes. It may be dumbbell in form, cone-shaped, or actually stellate. As stated by White, Smithwick, and Simeone,⁵ "Usually there is a distinct isthmus between the two halves, the upper component giving off rami to the three lowest cervical nerves, while the lower is connected to the first thoracic nerve by a large and a smaller ramus communicans." It is important to remember that, except in most unusual occasional variations, no further central connections occur above the first thoracic ramus; hence, in blocking the stellate ganglia, the sympathetic supply to the head will be completely interrupted.

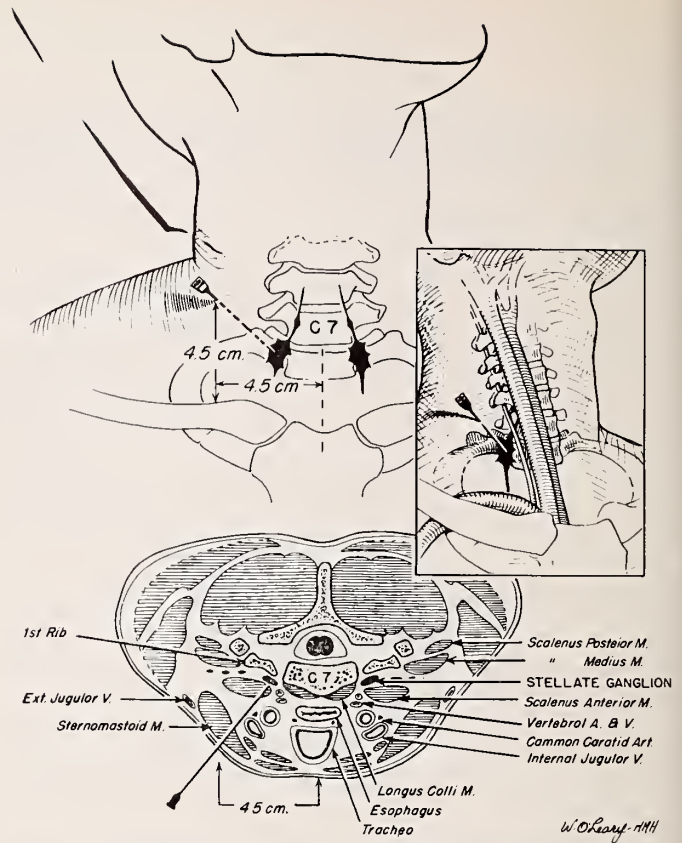


Figure 1: Anterolateral approach for stellate ganglion block. The needle is introduced inferiorly and medially through the skin approximately 4.5 cm. from the midline and 4.5 cm. above the superior border of the clavicle.

A variety of methods has been proposed for introducing a needle into, or in the vicinity of, the stellate ganglion. These may be divided into the anterior, anterolateral, lateral, and posterior approaches. The champions of each give good reasons for the method they use. We have used both the posterior and anterolateral approach, the latter being utilized in over 90 per cent of our stellate blocks. This is essentially the method described by Ochsner and DeBakey.⁶ They called it anterior but it is actually anterolateral as the location of the point of entry of the needle in the true anterior approach is considerably more medial.

Technique: Figure 1 shows the technique we have found most useful. In the anterolateral ap-



ABOUT THE AUTHOR

GEORGE P. WHITELOW, M.D. of Boston, Mass. graduated from Yale College in 1931 and from Harvard Medical School in 1935. He is at present engaged in the private practice of general surgery in Boston and is an associate professor of surgery at the Boston University School of Medicine. Dr. Whitelaw is also director of graduate training in surgery, Massachusetts Memorial Hospitals, and an assistant of the surgical teaching program, Boston University School of Medicine.

proach, a point on the skin approximately 4.5 cm. lateral to the midline and 4.5 cm. above the superior margin of the clavicle is selected. In piercing the skin 4.5 cm. above the clavicle, the needle point must be directed slightly inferiorly and medially. This necessary angulation is an additional safeguard against entry into the subarachnoid space. The needle is directed so that it will traverse the tissues just posterior and lateral to the carotid artery and internal jugular vein, piercing the anterior scalene muscle to touch on the most medial aspect of the first rib in the vicinity of the stellate ganglion. When the rib is felt, the needle is withdrawn about 2 mm. and 5 to 10 cc. of one per cent procaine or xylocaine is introduced.

As in all these blocking techniques, careful anesthetization of the skin and the tract to be followed by the needle will enable the procedure to be carried out with almost no discomfort. For the tip of the needle to reach its desired destination, the angulation of the needle from the point of its introduction through the skin is the most important consideration. The location of the head of the first rib must be kept in mind as the target. If it is missed on the first introduction, the needle may be withdrawn and reintroduced at a slightly different angle without any difficulty. If the needle tip is too far lateral and one of the cords of the brachial plexus is struck by it, typical pain radiation will divulge this fact. In utilizing the anterolateral approach, we have had only one instance in which a Horner's syndrome has not been produced.

Painful Upper Extremity Syndrome

Causalgias, post-traumatic syndrome, reflex dystrophy, painful phantom limb, and shoulder-hand syndrome can be placed in this general group. These apparently all have in common some disturbance of the vasomotor system. To those not particularly familiar with this syndrome, patients manifesting these symptoms appear to have a predisposing underlying psychogenic component. However, it is generally agreed by all who have studied and treated these cases that the so-called psychogenic factor is a result, rather than a cause, of the syndrome and when the pain is relieved, these manifestations disappear. Mayfield and Devine⁷ state that the personality changes always present during the painful stages are secondary to the pain. There was no evidence in their cases that a predisposing constitutional factor was present.

An essential feature of the pain of causalgia is its intensification by various stimuli that activate the sympathetic nervous system. This can be manifested by vasoconstriction or vasodilatation. All authors who discuss this syndrome agree that early

treatment is imperative. The longer treatment is delayed, the less successful are the results. Trophic changes, atrophy of bones, and stiffness of fingers and joints must not be allowed to develop. Procaine block of the sympathetic supply to the extremity is the most valuable initial procedure. In mild cases one or several blocks may cure the disorder. In the case of recurrence or lessened effect following several blocks, sympathectomy has been found to produce good results in approximately 75 per cent of the cases.

For the most part the various post-traumatic syndromes, other than causalgia, can be lumped into one category and are mostly due to a nonpenetrating injury without an obvious peripheral nerve lesion. Smithwick⁸ is of the opinion that these patients are more likely to respond to repeated blocks than is the group with causalgia.

Vascular Occlusion with Spasm

In the upper extremity, as is well known, the necessity of therapy for either arterial or venous disease is considerably more infrequent than in the lower extremities.

In cases of Raynaud's disease, Buerger's disease, and hyperhidrosis, in which there is clearly an indication for interruption of the sympathetic nervous system, stellate ganglion blocks, while occasionally helpful diagnostically, are not indicated therapeutically. Time, money, and false hopes can be better saved by proceeding with a dorsal sympathectomy.

However, there are instances of vascular disease in which stellate blocks may be extremely helpful in improving the circulation by overcoming the acute vasospastic phenomenon until collateral channels are better established or the affected main vessel relieved of its obstruction. Rarely, thrombosis of the subclavian or brachial artery may occur. Though dorsal sympathectomy, and occasionally amputation, may be the eventual outcome in some instances, stellate block may be an excellent interim therapeutic measure, and in some cases definitive, in conjunction with the usual other measures utilized for relief of arterial occlusion.

In instances of embolus of the brachial artery, particularly when accompanied by marked sensory and motor deficiency of the involved extremity, stellate block may be limb saving when combined with embolectomy. When brachial plexus block is elected as an anesthesia, stellate blocks are not necessary as the secondary vasospasm initiated by the primary insult is relieved by paralysis of the vasomotor fibers in conjunction with the regional anesthesia^{9,10}. For this reason, where not contraindicated, brachial plexus blocks should be utilized more often in conditions requiring operation and accompanied by possible damaging vasospasm in

the upper extremity. This principle also holds for spinal anesthesia in treating similar conditions involving the lower extremity. Ochsner and DeBakey¹¹ have been the foremost proponents of the principle of sympathetic block to overcome vasospasm secondary to thrombophlebitis. Occasionally thrombophlebitis with swelling and/or vasospasm may occur in the upper extremity and in such instances the same principles of therapy as enunciated for the lower extremity should be carried out.

Various viewpoints concerning the utilization of blocks in conjunction with anticoagulant therapy have been expressed. Hohf, Dye, and Julian¹² reported two instances of retroperitoneal hemorrhage which they believed were caused by lumbar sympathetic block concomitantly with controlled anticoagulant therapy. Ruben¹³ also sees a danger in repeated nerve blocking while giving anticoagulant therapy. Pratt,¹⁴ on the other hand, does not find any contraindication to concomitant use of anticoagulants and sympathetic nerve blocks in the treatment of vascular lesions. It is his opinion that blocks done correctly, even in the presence of anticoagulant drugs, would not produce dangerous hemorrhage.

It has been our practice for a number of years to use intermittent intravenous heparin for anticoagulant therapy and to perform the appropriate sympathetic block about an hour prior to the time for the next intravenous heparin injection. We believe that heparin is a more effective anticoagulant drug than dicumarol or related agents. According to the severity of the disease process and the sensitivity of the patient to heparin, the time interval of the hepa-

rin dose is adjusted, usually either every six hours or every eight hours. The initial dose is usually 75 mg., a sensitivity curve being run after the first dose. The blocks can thereby be adjusted so that danger from hemorrhage will be avoided. Usually blocks are performed every other, or every third day for a series of five or six. Oftentimes, two or three blocks will suffice. It has been our feeling that the postphlebotic syndrome can be avoided or at least lessened, particularly insofar as the swelling is concerned, if blocking procedures are carried out during the active phase of the disease in those cases in which vasospasm and/or swelling is present. We would be very loathe to perform blocks on patients who were receiving anticoagulant therapy by mouth or continuous intravenous therapy. Insofar as we are aware, in utilizing the technique of intermittent intravenous heparin over a period of seven years, there have been no instances of post-block hemorrhage. There were a few instances of upper extremity involvement demanding sympathetic block in addition to anticoagulant therapy but over 95 per cent of the cases were for involvement of the lower extremity.

Lumbar Sympathetic Blocks

Although somewhat more difficult to carry out effectively, and without discomfort, lumbar sympathetic block is performed for conditions of vasomotor imbalance involving the lower extremities similar to those already discussed in the upper extremity for which stellate ganglion block is employed. In the painful lower extremity syndrome, which includes causalgia, post-traumatic syndrome, reflex dystrophy and painful phantom limb, lumbar sympathetic block may be very effective. Cases of vascular occlusion with spasm, both arterial and venous, in the lower extremity are treated like similar conditions in the upper extremity.

Technique. In the performance of lumbar sympathetic blocks, we use only two needles (Figure 2). The first is placed approximately 4 cm. from the midline, at the level of the superior border of the spinous process. Following its introduction, direct contact will be made with the transverse process of the second lumbar vertebra. Then the rubber marker is adjusted to a distance of 3.5 cm. from the skin and the tip of the needle is angulated so that it will pass just above the transverse process in a medial direction toward the anterolateral aspect of the body of the vertebra. Following the introduction of 8 to 10 cc. of one per cent procaine, the needle is brought back to the subcutaneous level and re-directed so that it now passes just below the second lumbar transverse process. A similar procedure is carried out with one needle at the third lumbar transverse process (Figure 3).

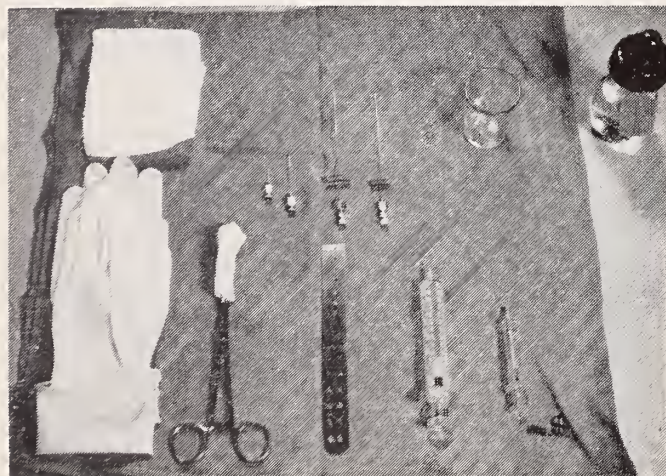


Figure 2: Block set for stellate and lumbar ganglia. Gloves, sponge for skin preparation, No. 26 and No. 22 needle for intradermal and subcutaneous injection and two No. 22 needles with skin markers are necessary along with a 2 cc. syringe for introducing procaine in the path to be followed by the needle and a 10 cc. syringe for use when the needle is in place. A ruler is helpful in placing the rubber markers on the needle in the lumbar sympathetic blocks.

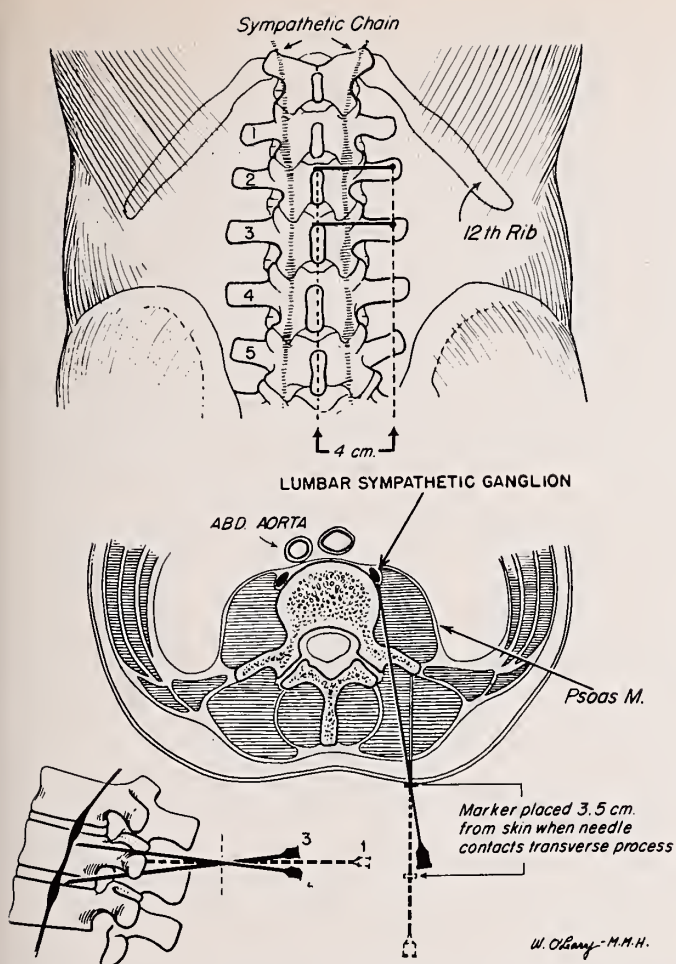


Figure 3: Lumbar sympathetic block. Each needle is introduced 4 cm. from the midline to the level of L₂ and L₃ transverse processes. The direction is then changed, and the tip of the needle passed an additional 3.5 cm. in a medial direction both superiorly and inferiorly to the transverse process of L₂ and L₃.

In this manner, a high percentage of successful blocks will be accomplished as the chances are increased for effective blockade of an anomalous second lumbar ganglion by this technique. The great anatomical variation of the lumbar sympathetic ganglia is well known. Yeager and Cowley¹⁵ have discussed this matter. Only infrequently do central connections exist below the second lumbar outflow; hence, allowing for anatomical variations in the location of the second lumbar ganglion as well as the occasional central third lumbar connection, the use of two needles is adequate and effective in blocking the vasomotor outflow to the lower extremity.

Crossed connections from right to left or vice versa, is an interesting anatomical variant that must be very rare. This is discussed by Kleinman¹⁶ and mentioned by Yeager and Cowley as accounting for occasional failures following lumbar sympathetic block or sympathectomy.

Somatic Nerve Blocks

We have had no experience in blocking cranial nerves as these procedures should in our opinion be confined to the field of neurosurgery. We have done intercostal nerve block for painful incisions follow-

ing transthoracic maneuvers. We have also performed these blocks during transthoracic operations in order to prevent the occurrence of painful wounds when portions of the sympathetic system are removed, and have employed various techniques of injection of some of the long-lasting agents such as dolamine, Nupercaine-in-Oil,[®] efocaine, and five per cent tannic acid, which generally proved unsatisfactory for this purpose. Our results indicate that neuritis following operations involving removal of portions of the sympathetic nervous system is a more frequent occurrence than after a similar operation without removal of a portion of the sympathetic nervous system. For example, neuritis follows lumbar sympathectomy more frequently than removal of a retroperitoneal tumor in the lumbar region through a similar incision. The explanation of this is obscure although it may be due to some phenomenon connected with sympathetic nerve denervation following operation. Recently we have removed the entire intercostal nerve below the rib resected in the transthoracic approach, and this seems to be helpful in diminishing postoperative pain according to a limited experience. The nerve is resected with the dorsal root ganglion. This is usually followed by a spinal fluid leak. By this method, the problem of regeneration and neuroma formation may be decreased.

A technique for paravertebral somatic nerve block is described by Shaw.¹⁷ Unless the posterior division of the nerve is involved, the block can be more simply performed approximately 7 to 8 cm. from the midline posteriorly (Figure 4). In a few instances, we have noted an increase of the neuritic pain following the nerve blocking maneuver. If intercostal pain becomes intractable and unrelieved by blocking maneuvers, resection of the involved nerve or nerves intraspinally may have to be carried out.

The use of somatic nerve blocks has been described for a great variety of indications.^{18,19,20} In certain cases of severe pruritus vulvae and ani, we

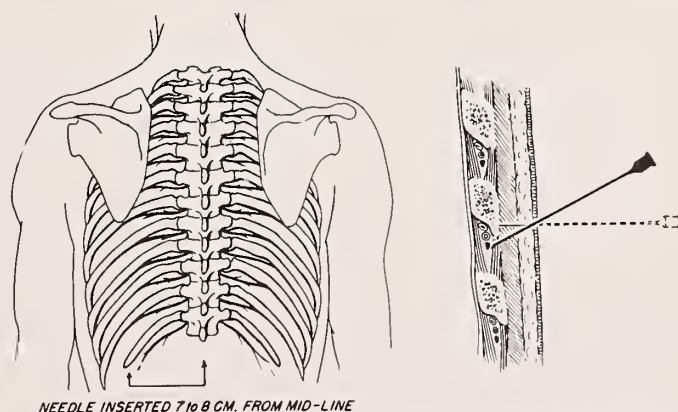


Figure 4: Intercostal nerve block. A No. 22 needle is inserted approximately 7-8 cm. from the midline posteriorly until the rib is felt. It is then redirected inferiorly just below the rib to an additional distance of 2-3 mm.

have used subcutaneous injection of one per cent procaine approximately 4 cm. from the midline around the vulva and anus, confined to the side involved. This is followed by injection of efocaine through a No. 22 needle. It is emphasized the efocaine should be deposited in a very fine stream, withdrawing the needle slowly as the injection is started. In this way, there will be no pooling of efocaine and hence undesirable reactions from slough and infection will be avoided.

Miscellaneous

On surveying the literature on this subject, one is impressed by the great variety of conditions for which different authors advocate the use of blocking procedures. Nerve blocks for these various conditions fall into one of three categories: (1) worthless, (2) deserve further investigation and trial, and (3) of definite value. The scope of this paper and our experience does not allow for a separate critique of all these conditions. A few comments will be made, however, concerning our impressions relative to some of them.

Bursitis. In bursitis, particularly about the shoulder joint, we have had most satisfactory results following injection therapy into the area as determined by the point of maximal tenderness. We have usually utilized one per cent procaine and approximately 1 cc. of hydrocortisone. We have not used stellate ganglion blocks for this condition but have followed unsuccessful attempts at injection therapy by X-ray treatment to the involved site. Insofar as we are aware, there have been no complications from this type of therapy.

Herpes Zoster. In the severe pain of herpes zoster not controlled by the usual methods, blocking the appropriate portion of the sympathetic nervous system may be extremely helpful. In cases of long-standing postherpetic pain, however, we are not impressed with this treatment.

Scalenus Anticus Syndrome. Injection therapy for the diagnosis and/or treatment of scalenus anticus syndrome seems to be of only limited value. The proximity of the anterior scalene muscle to the stellate ganglion must be remembered, as results of injection may be attributed to the muscle infiltration when in fact it is due to sympathetic blockade. Following scalenus infiltration, the Horner's syndrome will give an indication whether or not the ganglion has been blocked in addition to the muscle.

Arthritis. Our experience with the injection of procaine, followed by hydrocortisone, in or about painful arthritic joints, has met with sufficient success to cause us to utilize this procedure when the

usually recognized more conservative measures have failed to control the joint pain.

Summary

Our impressions concerning the effectiveness of blocking procedures in certain conditions with which we have had experience has been discussed particularly in reference to the sympathetic nervous system. Most of this discussion involves the relief of pain syndromes. In 1938, Cutler¹³ stated that "pain is the symptom that brings most patients to the doctor. There are two types of pain arising through separate mechanisms. There is somatic pain arising in relation to changes in the central nervous system and there is visceral and vascular pain, apparently having to do with changes in the autonomic nervous system. Autonomic or sympathetic pain is capricious; it occurs in a less limited field; it frequently overflows; it varies greatly in intensity with different attacks; it is aggravated by the emotions and by barometric pressure; and it bears a more distinct relation to the individuality of the patient." The early interest of Cutler and others in this field began to open the trail through a thick forest of ignorance. Further pursuit of this trail is in progress today though we have as yet advanced only a short way.

Burdick²² best expresses our attitude toward this whole subject when he says, "It is surprising that the medical profession as a whole is so unaware of the values inherent in therapeutic nerve block procedures. Like all other branches of therapy, it has its shortcomings and its limitations and makes no panacean claims. It has proved its worth in conditions not always responsive to other methods of control. Postponement more than any other factor has mitigated against better results. Its minimal complications in experienced hands and its noninterference with other forms of treatment favor wider adoption. While accomplishment in certain instances leaves much to be desired, the really high percentage of success not only in pain alleviation but in influencing favorably the outcome of disease processes merits more serious consideration."

203 Commonwealth Avenue

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MONTH IN WASHINGTON

IF EVERY MEMBER OF CONGRESS had his way, there would be anywhere from 10 to 15 institutes at the National Institutes of Health in Bethesda. The total now stands at seven, and there is a good possibility that an eighth will be in operation this year or next.

Fifty-eight Senators of both parties joined in sponsoring a resolution that would do three things: (1) establish a National Institute for International Medical Research, (2) create a National Advisory Council for International Medical Research, and (3) authorize \$50 million annually for international research programs. Senator Lister Hill (D., Ala.) a leader in health legislation and health welfare appropriations, has taken the lead in pushing this bill.

Four days of hearings brought almost unanimous support of the resolution, only two witnesses complaining it did not go far enough. The administration asked for three postponements to testify. This gave rise to speculation that it either may object on budgetary grounds or dissatisfaction over location of the institute.

Dr. Gunnar Gundersen, American Medical Association president, pledged full support and assistance of the AMA for the project. "... we believe that the promotion of international health through research is one of the best means of promoting international cooperation and understanding." He noted "a growing recognition that medicine, with its resources and influence fully mobilized, can perhaps do more for world peace than the billions of dollars being poured into armaments."

The AMA president made several suggestions for the committee's consideration; including (1) that the World Medical Association be included among the international groups to be cooperated

with, (2) that due care be taken not to "rob" other countries of experts in medical care and scientific research through support grants not geared to salary differentials, (3) that the program should be primarily one of research itself rather than construction of research facilities, and (4) that the greatest care be exercised in setting up the research grants and research programs to avoid overlapping or duplicating.

Notes:

The Forand bill for hospitalization and surgical services of retired social security recipients has been introduced in only slightly revised form. Its number is H.R. 4700. One change of interest is permitting surgical services to be performed by other than board-certified surgeons. The author says the program will be financed by increasing social security taxes (above increases already scheduled) by one-fourth of one per cent for both employer and employee and three-eighths of one per cent for the self-employed, both starting in 1960.

More significant than even the introduction of the bill was the statement Mr. Forand filed in the Congressional Record the same day. It was moderate in tone and seemed to be asking the support of all groups. He noted, for instance, that some of his strongest backers have questioned the inclusion at this time of surgical services.

This, he commented, should be weighed by the committee when it takes up the bill.

On hearings, little is known. Neither the House Leadership nor Chairman Wilbur Mills of Ways and Means Committee have given any indication when hearings would be held.

THE EHLERS-DANLOS SYNDROME

This disorder of the connective tissue is characterized by hyperelasticity and increased fragility of the skin along with hyperextensibility of the joints.

Fred E. Goldwasser, M.D., *Alma*

THE EHLERS-DANLOS SYNDROME is one of the hereditary disorders of connective tissue. Because of its rarity, it is considered something of a medical curiosity. Only about 100 cases have been reported in all world literature from 1682 to the present time. It is the purpose of this paper to report a recently discovered case of Ehlers-Danlos syndrome.

Case Report

J. V., a ten year old, white female, was brought in to the hospital on August 20, 1958 with a severe horizontal laceration on the anterior aspect of the left leg. The wound gaped very widely. In spite of this gaping, there was a very little bleeding from the wound. This severe laceration was sustained by a relatively mild trauma. The child had bumped her leg rather gently against a smooth, round portion of a lightweight, aluminum chair. Upon first inspection of the wound, the impression was obtained that it would be extremely difficult to approximate the edges of the wound because of the wide amount of gaping. However, the process of surgical repair was really very simple because of the marked elasticity of the skin. There was no difficulty at all in securing complete and perfect approximation of all the tissues.

The wide gaping of the original wound, the ab-

sence of bleeding in spite of the ugly appearance of the wound, and the ease of approximation of the



Figure 1: Illustrates mongoloid appearance.

The author wishes to express his appreciation to Dr. Arthur M. Knight, Jr. of Waycross, who has done considerable work in this and related diseases and who kindly offered much help in preparation of this paper.



Figure 2: Illustrating telangiectases and hyperelasticity of skin.

tissues led to a further investigation of the case.

Several unusual findings were elicited in the courses of a general physical examination. The skin over the entire body was extremely soft. It felt like a piece of fine velvet or very soft foam rubber. It was rather pale in appearance although there was no laboratory evidence of anemia. All over the body, particularly on the extremities, there were numerous scars. Several of the scars showed fine telangiectases. The skin was found to be capable of being stretched to surprising lengths. This capability for being stretched was most marked over the bony prominences of the knees and elbows. In the subcutaneous tissue of both legs, a few small, hard, movable nodules were felt.

The various joints of the body showed extreme hyperextensibility. This looseness of the joints was most manifest in the wrists and fingers. Muscular tone throughout the body appeared to be considerably less than normal.

The child had the physical appearance of a mongoloid individual. However, there was no evidence, whatsoever, of any mental retardation.

An attempt was then made to find out whether other members of the family were similarly affected. No other person either closely or remotely related to the patient was found to have this type of condition.

Comment

The Ehlers-Danlos syndrome is a condition, supposedly of hereditary origin, which is characterized by hyperelasticity of the skin, increased fragility of the skin, and hyperextensibility of the joints. There are other manifestations which do occur but they are not essential to the diagnosis.

The disorder obviously involves the connective tissue. There is still considerable controversy as to the exact pathology present. It seems to be that the disturbance involves the collagen fibers. There is probably some alteration in the molecular structure



Figure 3: Illustrating hyperextensibility of joints.

of these fibers. As a consequence of this alteration in molecular structure, the collagen fibers become less resistant to stretching.

Thus far, there is no specific treatment for this syndrome. Care should be taken to avoid trauma of any sort. Special care should be taken by the physician in the repair of lacerations in these patients. Whenever sutures are removed in such a patient, it is probably wise to reinforce the healing suture line with a few strips of adhesive tape. The hyperextensible joints may require braces or even surgery.

It is important to remember that some of the cardinal signs of the syndrome may be minimal or absent in the formes frustes.

Alma, Georgia

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COUNTY MEDICAL SOCIETY ORGANIZATION

Arthur M. Knight, M.D., *Waycross*

THE MEMBERSHIP OF THE County Medical Society should elect a small number of officers, who, in turn, should appoint a large portion of the membership to serve on various committees and thus conduct the society's business. The elected officers should consist of a president, vice-president, secretary, treasurer, and a number of delegates and alternates who represent the society at meetings of the Medical Association of Georgia. Under the Constitution of the Medical Association of Georgia, each component society shall elect one delegate and a corresponding alternate, each of whom has been a member in good standing for the prior three years, for each 25 members, or fraction thereof, whose dues have been paid by December 31st of the preceding year, provided that each component county society shall be entitled to at least one delegate. In addition to these officers, larger societies should have a full-time executive secretary and a public relations counselor (who can be part-time).

The President

The president should preside at the meetings of the society and appoint all committees not elected. He is the society's main representative to the public. He should represent the society at functions of all sorts of civic organizations when the need arises (such as Georgia Education Association, County Pharmaceutical Association, voluntary health organizations, and similar groups). His is a difficult job and he should be carefully selected. He deserves the deepest gratitude for his work.

The Vice-President

The vice-president is the president's stand-in.

He takes over any functions which the president cannot handle. In many societies he is by tradition the chairman of the public relations committee, which gives him a vantage point from which to gain experience for the job of president.

The Secretary

The secretary has the responsibility of keeping the records of the society and its meetings and sending out all the notices and communications necessary for the running of the organization. He also has the responsibility of being the parliamentarian at meetings and should be an expert on Robert's Rules of Order. Some societies pay the secretary an annual stipend. He often passes this on to his own secretary who does most of the actual work.

The Treasurer

The treasurer is responsible for the money. He has the responsibility of collecting it, spending it, and keeping it. This can be a difficult job, especially if the county society has a group insurance program.

The Executive Secretary

The larger societies may have an executive secretary on a full-time basis. In smaller societies the secretary's private secretary may be paid a small salary, as indicated above, to take over these duties on a part-time basis. The executive secretary should work with the secretary and other officers to do the actual work of running the organization. It is she, at the direction of the officers, who keeps the minutes, writes the letters, sends out the bills, and keeps things running.

The large county societies will have a full-time executive secretary who sits in the office of the county medical society. Thus, she becomes the society's

number one representative to the general public and answers numerous queries on the telephone, in person, and in the mails, directed to the county society. Her job requires the rare combination of diligence, competence, patience, and tact.

Public Relations Counselor

Large medical societies should have a public relations counselor. It should be his job to represent the society and organized medicine to the press, radio, and television. He should try to show the medical profession in its most favorable light. He should try to bring all of our messages to the attention of the public. This job becomes more important every day with growing social and economic pressures.

Committees

The number of committees a medical society might have will depend on its size and the special needs and problems in its particular community. The committees listed here represent an example of the organization of a very large county society. Smaller societies would combine some of these and perhaps eliminate some as unnecessary. The following is a suggested list of committees:

1. Executive
2. Judicial
3. Legislative
4. Membership
5. Nominating
6. Public Relations
7. Budget and Finance
8. Publications
9. Scientific Program
10. Entertainment
11. Business Office
12. Civil Defense and Disaster Control
13. Public Welfare
 - a. Cancer Control
 - b. Heart Disease
 - c. Diabetes
 - d. Conservation of Vision and Hearing
 - e. Crippled Children
 - f. Maternal Welfare
 - g. Mental Hygiene
 - h. Public Health
 - i. School Physicians
14. Medical Practice
 - a. General Practice
 - b. Insurance
 - c. Liaison
 - d. Pharmaceutical

- e. Post-Graduate Education
- f. Medical Economics
15. Constitution and By-Laws
16. Blood Bank
17. Building
18. Compensation Insurance
19. Representatives to Public Welfare Department
20. Advisors to State or County Agencies

The executive committee is the steering body of the county society. Its membership will vary according to the size of the society. The following is a suggested membership list:

- a) President, vice-president, secretary, treasurer
- b) Three to five past presidents
- c) The chairman of each of the following committees:
 1. Public Welfare
 2. Medical Practice
 3. Constitution and By-Laws
 4. Judicial
 5. Legislative
 6. Membership
 7. Nominating
 8. Public Relations

Each member holds office for one year. The chairman is the county society president. The committee meets once a month and conducts the society's business with the approval of the society. Typically, the meeting may be held one week after the regular society meeting (which is also held once a month). Minutes are read and approved. Applications for membership are taken up. Correspondence is read and answers proposed. Old and new business matters are discussed. The treasurer's report is checked. Reports from committees are received. The first portion of the meeting may be an open meeting and the last portion a closed meeting or executive session.

In the smaller societies which have fewer committees, there will be no executive committee and most of the functions listed will be handled by the entire membership of the society in its monthly business meeting. In such cases, applications for membership are processed by the Board of Censors which serves both judicial and membership functions.

The judicial committee in the larger societies might consist of five members elected, one annually, for a five-year term (the term of one member to expire each year). This committee rules on all questions of ethics and all complaints against members. It disposes of complaints by dismissal of the complaint, censure, suspension, or expulsion of the member in question. All matters are confidential. The committee has the power to summon any

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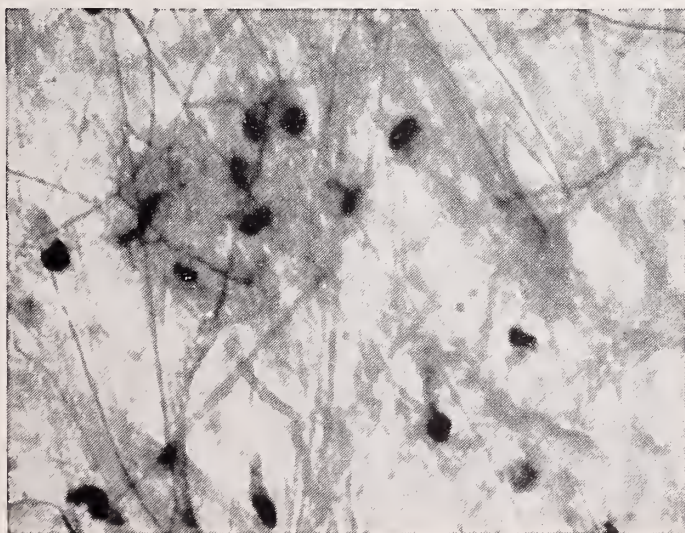
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member before it. Appeals against its decisions may be made by either of the parties involved. In smaller societies these functions are handled by the board of censors which might consist of three members elected for three year terms on a staggered basis. (In some societies these functions are shared by the grievance committee and the public relations committee. In any event, there must be good liaison between public relations, grievance, board of censors, and judicial committees.)

The legislative committee keeps an eye on the goings-on in Congress and in the State Legislature. They keep a special watch for laws which would interfere with the best type of medical practice, such as injecting government into general medical care or the licensing of faith healers and cultists (such as naturopaths and osteopaths). It should send letters of appreciation to legislators for their help in passing laws which are of benefit to the medical profession. It also has the responsibility of prosecuting quacks and medical pretenders.

The membership committee has the duty to examine the credentials of potential members and to report on them to the executive committee.

Smaller Societies

In the smaller societies, the board of censors will report to the business meeting of the entire society. It should actually interview new applicants for the double purpose of (1) meeting them personally and of (2) introducing them to the customs and usages in the county. A few larger societies have indoctrination courses. A few societies throughout the country have probationary periods for new members. This committee has a great responsibility to insure that only reputable, ethical, qualified men are granted medical society membership.

The nominating committee should have the immediate past-president as its chairman. It should present a selection of candidates for the various offices of the society for election for the coming year. It has the responsibility of determining the fitness and availability of candidates for office.

The public relations committee should supervise publicity for the society and assume any function which may better the relations between the public and the medical profession. It is wise to have as its chairman the society vice-president. It might make and publish a list of doctors willing to make house calls or emergency calls. It should keep a list of doctors ready and willing to make public speeches on various subjects. It should investigate complaints

about failures to secure doctors for emergency calls and should maintain liaison with the judicial committee. (The grievance committee may be a subcommittee of the public relations committee. In some areas, the names "grievance committee" and "public relations committee" are used interchangeably). The public relations committee should employ the public relations counsel and supervise his work. It may organize public forums. It may advertise in newspapers or elsewhere when indicated. It should keep in touch with the advertising campaigns of the American Medical Association. It should also keep a list of educational films available for public showing. It should try to develop a "code of cooperation" for the society's relations with government, civic groups, other professions, hospitals, and the general public. It should devise a plan by which doctors will always be available for emergencies. It should express the appreciation of the society for outstanding achievements of individuals and organizations in promoting health, medical progress, medical public relations, medical legislation, etc. (It should maintain good liaison with the legislative committee). It should advise the public on such problems as fluoridization of drinking water, sanitary garbage disposal, vaccination programs, public health examinations, and similar projects.

The budget and finance committee should consist of three to five members whose duties are to act as auditors of the financial transactions of the society and to present a comprehensive budget for each coming year.

Very Large Societies

Very large societies will need a bulletin committee or publications committee. Its chairman should be the editor of the society bulletin.

The scientific committee may be called the program committee. It prepares the scientific programs for the society meetings throughout the year. It arranges for speakers and sounds out the members on what subjects they would like to hear discussed.

The entertainment committee arranges for the society's social events. Smaller societies often have a dinner meeting each month and larger ones only an annual banquet. Many pharmaceutical houses are interested in entertaining the doctors and should work through this committee. There should be good liaison with the entertainment committee of the Woman's Auxiliary.

The very large society will need a business office committee with three members to take care of matters which involve the society headquarters such

as the location of the office, records, personnel, and similar problems.

Every county society should have a civil defense and disaster control committee. Atomic warfare is a real possibility. This committee should establish definite plans to meet catastrophe and to shake the physicians out of their indifference. It should maintain liaison with the American Red Cross and with the Federal Civil Defense Program.

Sub-Committees

The committee on medical practice in the larger societies might consist of the chairmen of six appointed sub-committees: (a) general practice, (b) insurance, (c) medical economics, (d) liaison, (e) pharmaceutical, and (f) post-graduate education.

The general practice committee works for establishment of a general practice staff in local hospitals. It attempts to organize a local chapter of the American Academy of General Practice. It may aid in formulating fee schedules for general practitioners. It may also tackle the special insurance problems of the general practitioner and other matters limited to this field of medical practice.

The insurance committee in some of the larger medical societies in the United States works out group insurance plans for society members. In many states group insurance is handled by the state organization rather than by the county society. Group insurance is available for hospitalization, life, malpractice, professional liability, accident, disability, and many other hazards. This committee should maintain liaison with the State Insurance Commissioner and the Insurance Committee of the State Medical Association, regional (Southern) Medical Association, and specialty groups (American College of Physicians, American College of Surgeons, and others). It should urge adequate malpractice insurance for members of the society.

The medical economics committee should keep available helpful information regarding the business side of medical practice. It could organize a physicians credit information service. It could help new doctors to find suitable locations. In some county societies, it operates a collection agency, and in others it supervises budget plans for patients. In some areas it even engages in cooperative buying for physicians' offices. It could operate a personnel bureau for office assistants, technicians, and other medical aides. It should maintain liaison with the legislative, budget and finance, business office, and other related committees.

The liaison committee acts as advisor to the Woman's Auxiliary, County Dental Society, and other professional, semi-professional, and lay groups

with interests in common. It should maintain close contact with the public relations committee.

The pharmaceutical committee could be combined with the liaison committee to maintain liaison with the county pharmaceutical society. It can also iron out problems of night, Sunday, and holiday coverage by pharmacies.

The post-graduate education committee should seek to arrange for post-graduate courses to be offered for physicians of the county. It can work through the medical schools, State Medical Association, American Medical Association, and voluntary health organizations.

The public welfare committee should be composed of the chairmen of its subcommittees, such as cancer, heart disease, conservation of vision and hearing, crippled children's committee, maternal welfare, mental health, public health, venereal disease, tuberculosis, and others.

The chairman of the public welfare committee should act as coordinator of these various subcommittees and report on their work to the executive committee, making whatever recommendations he sees fit.

The cancer subcommittee keeps the society informed about the work of the American Cancer Society and new developments in cancer detection. It may conduct panel discussions before lay groups and similar projects.

The cardiovascular committee can bring about formation of a local chapter of the State Heart Association. Its members may give talks to further professional and lay education on heart disease.

The crippled children's committee maintains liaison with the National Foundation for Infantile Paralysis, the Cerebral Palsy Foundation, the State Crippled Children's Service, and similar groups.

The maternal welfare committee may investigate all maternal deaths in the county and make appropriate recommendations. It may engage in educational activities. It may embark on projects such as an Rh-Negative Blood Donor's Club.

The mental health committee cooperates with state and national agencies in educational activities and acts in an advisory capacity.

The public health committee maintains liaison with public health agencies and also with voluntary health agencies not covered by other committees. It cooperates actively in every way possible and reasonable.

Constitution and By-Laws

The constitution and by-laws committee is responsible for formulating and revising the constitution of the society. It should constantly review and

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revise as indicated. It should publish the constitution and by-laws and make them readily available to all members. It should be guided by the publication "Constitution and By-Laws for County Societies" prepared by a committee on organization of the American Medical Association and available from AMA headquarters.

The blood bank committee can work for the establishment of a county blood bank. It can solicit funds for this purpose. It can advise on or supervise blood banking procedures. It can aid in securing donors and engage in other helpful activities.

A building committee may be needed to acquire a building suitable for society headquarters or the blood bank.

Other committees often appointed include re-

habilitation, geriatrics, federal medical service, chronic illness, hospital relations, and others. Medical society committees can be multiplied endlessly with new committees being added as the need arises. But committees should be made to interlock in their interests and responsibilities, and excellent liaison should be maintained at all levels. Whenever possible, committees should be combined to prevent the structure of the medical society organization from becoming too cumbersome, unwieldy, and inefficient. This is especially true in small societies where only a few members in each of a small number of committees of wide scope can carry on efficiently all of the interests of the county society.

P.O. Box 899

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A RESOLUTION

ON SUNDAY, SEPTEMBER 14, 1958, Waycross and all of Georgia were grieved when Dr. Benjamin Harvey Minchew, a loyal member of the Ware County Medical Society was called to a higher field of service. To those who knew him well, his departure has brought deep sorrow because his place can not be filled. Even to those who knew him slightly his passing has brought sincere regret because his was a life of public service, dedicated to all who needed his helping hand, his cheerful smile. The words "To know him was to love him" are truly symbolical of the life he lived and of the deep affection in which he was held.

We, the members of the Ware County Medical Society, feel that we have suffered an irreparable loss because he was an outstanding specialist, unexcelled in his field. He was a loving family friend to those who needed his assistance. Dr. Minchew served in many places of responsibility in our local society. He was ever ready to perform any duty that would foster the growth of our society. In the Medical Association of Georgia he served on many influential committees before he was given the highest honor, that of President of the Association. For many years he served as delegate to the American Medical Association.

We grieve that our friend can not serve with us

now. We miss his cheerful spirit, his loyalty, his devotion, his inspiring courage and his deep abiding faith, yet we rejoice in the knowledge that he has been called to a higher reward; the reward that is his for his life of Christian service and faith.

The passing of our friend and co-worker removes a tried and trusted link from our chain of service but the example set by his life of devotion to duty inspires us to gather up the broken threads and forge another link of hope, faith, and love that will bind us closer to each other, to him, and to the GREAT PHYSICIAN.

Whereas God, in His Infinite wisdom, has seen fit to call our dear friend and fellow physician from us, we therefore resolve:

First, that we bow in humble submission to His will, knowing that He doeth all things well.

Second, that we express our sympathy to the family by sending them a copy of these resolutions.

Third, that a copy of these resolutions be incorporated in our minutes and published in the Waycross Journal Herald.

Respectfully submitted:

Dr. D. M. Bradley

Dr. J. E. Penland, Chairman

FILM RELEASE BY AMERICAN COLLEGE OF RADIOLOGY

A MOTION PICTURE ILLUSTRATING the medical aspects of radiation, including protective measures in diagnostic radiologic examinations, will be distributed soon by the American College of Radiology to the nation's physicians.

Supervising production of the 16 mm., half-hour color film will be a special committee of the American College of Radiology under the chairmanship of Wendell G. Scott, M.D., professor of clinical radiology, Washington University School of Medicine, St. Louis, Mo.

Also members of the supervising committee are Richard H. Chamberlain, M.D., professor of radiology, University of Pennsylvania School of Medi-

cine, Philadelphia, Pa.; Philip J. Hodes, M.D., professor of radiology, Jefferson Medical College, Philadelphia, Pa; Ted F. Leigh, M.D., professor of radiology, Emory University School of Medicine, Atlanta, Ga.; and Donald Chadwick, M.D., and Arthur Wolff, D.V.M., both of the United States Public Health Service, Washington, D.C.

Premier showing of the film is June 9, 1959, at the meeting of the American Medical Association in Atlantic City, N. J. Following the premier, prints will be released immediately for distribution among the medical profession for showings at scientific programs, medical conventions, medical society meetings, hospital medical staff meetings, and hospital association conventions.

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editorials

Tranquilizers

THE DUTY AND DESIRE of every physician is to relieve suffering, whether it is physical or mental. The customary method of accomplishing this goal is by the use of medication with chemical agents of various kinds. Confronted with patients suffering from emotional difficulties, the physician finds a need for agents to relieve the suffering and functional disturbances sequel to it. To meet this demand, there has been a widespread search for chemical agents to bring about the desired calming effect. The physician is under the pressure of his own desire to be helpful and the demands of the patient for a quick cure as related in the latest edition of a current periodical. Because of the extensive use of the agents already introduced, the race is on among the manufacturers to find their own special preparation. The agents introduced thus far fall into several categories such as muscle relaxants, antihistaminics, and depressants.

While the claims imply that these agents are not sedatives, patients taking them experience a sedative effect or none at all. In addition, these agents have side effects which range from mere discomfort to considerable annoyance, and sometimes to troublesome physiologic disturbances. These agents usually are studied extensively on the large populations of state mental hospitals, and are used on patients with various psychoses. By inference, the agents then are supposed to be useful in the treatment of

the patients seen in the office practice of the average physician. In institutions the agents are used to return the patients to reality; in private practice they are used to escape reality. To treat a severe condition which results in the total disorganization of an individual with large doses of a medication and then to assume that such an agent in smaller doses will be effective in the treatment of minor emotional difficulties of a different nature may lead to disappointment.

It is important to realize that the use of these agents may be comparable to the treatment of fractures by issuing wheel chairs. The temporary use of such agents is justified as a part of a planned study and treatment program for the patient. The use of the medication does not relieve the physician of the necessity to take the time to find the true factors producing the symptoms. The responsibility to help the patient face the real problem cannot be evaded. Using the agents in the manner of using insulin results in the tendency to take the medication in increasing amounts and for prolonged periods of time and becomes a self-defeating measure. Habituation or dependency may be the compromise which the patient accepts.

It is a long step from the prescription of pregnancy to relieve emotional distress to the use of the newest tranquilizer. The treatment may result in a complication of the condition rather than an allevia-

tion of the difficulty. Sound medical judgment and the ultimate health of the patient must be the prime consideration. Certainly sound medical judgment must be utilized in the use of these agents. The tranquilizer is only a part of the therapeutic regimen necessary for the ultimate rehabilitation of the patient. Indiscriminate use of these agents will bring them into justifiable disrepute.

The successful use of tranquilizers requires a careful study of the patient and his social environment. The psychogenic effect of all medication must not be ignored. Special care must be taken to avoid prescribing tranquilizers for individuals in whom a depression is masked by tension for the medication will deepen the depression. In the treatment of emotional disturbances, the effects of the tranquilizers are inconstant and unpredictable. Prolonged use of tranquilizers may delay more definitive treatment for the emotional condition present.

Double blind studies have not only shown that the desired effects are obtained from placebos but also that some of the most distressing side effects

may result from these alternate substances. Evaluation of the studies from large institutional populations suggest that in some instances the gratifying results come about more from the increased interest in the patient and the changes in his environment than from the agent itself. It has been suggested that the drugs had a beneficial effect by increasing the enthusiasm and the optimism of the staff which became contagious to the patient. This cannot be ignored in the everyday use of the medication. That a medicine is as good as the physician prescribing it has long been an accepted fact. The most confusing element is the idea of pacificity. This can mislead the physician in his efforts and lull him into complacency in the evaluation of the total patient and his environment.

These agents are therapeutic adjuncts in the management of the emotionally disturbed individual. They cannot take the place of sound judgment and thorough knowledge of the actions, side effects, and limitations of the agents.

Joseph S. Skobba, M.D.

Legislation Without Representation

“THE HOUSE OF DELEGATES is the legislative body of the Association . . . each component county shall elect one delegate and a corresponding alternate for each 25 members, or fraction thereof . . .”¹ So reads the Medical Association of Georgia Constitution and By-Laws. Its intent is clear—in short, the MAG House of Delegates is the representation of the house of medicine in Georgia.

These principles of democratic organization are meaningless unless the responsibilities of the duly elected county society delegates are fulfilled. The purposes of the House of Delegates can only be achieved when *all* component county societies are represented. At the 1958 session of the House some 23 out of 73 societies *were* not represented at the first session and at the second session some 39 societies of 73 had *no* representative in attendance. In the 1957 session 30 county societies out of 74 *missed* the first session and some 29 societies of 74 *absent* at the second session.

How then can an organization truly represent its membership? The fault clearly lies with the society and its delegate; not with the organization. It has been said that if the electorate cares not to vote—it does not merit the right to vote. Your Association can only urge each society to insure through its

delegate the representation of the society. Societies must charge their delegates with the responsibility of attending both sessions of the House of Delegates at the MAG Annual meeting, or the House of Delegates, like the proverbial house of cards, will not endure.

Early history records a tea party held in Boston to insist on the right of representation. Our great nation is dedicated to each individual's right of voice in governmental affairs. And organized medicine in Georgia is similarly conceived in democratic principle. These are “high sounding” phrases and words. Strong words, but it all boils down to the fact that the MAG House of Delegates speaks for the component societies—and the societies must be an active part of that voice which in unison represents the physicians in Georgia.

The MAG House of Delegates meets Sunday afternoon at 5:00 P.M., May 17, 1959, Crystal Room, Bon Air Hotel, Augusta (first session) and again on Wednesday morning at 9:00 A.M., May 20, Crystal Room, Bon Air Hotel. Pledge your society's support by having your delegates present and voting. Make the 1959 House sessions represent the length and breadth of Georgia medicine!

Editorials continued on page 190

Medical Care or Politics

WISHING WON'T FREE American Medicine. We must not sacrifice our heritage for an easy way out.

The 1959 version of the Forand bill has been introduced in the House of Representatives under a new number, H. R. 4700. It is the same bill (H. R. 9467) introduced in 1957, with a few minor changes.

The Truman administration tried to enact an all out compulsory health insurance law known as the Murray Wagner Dingell bill during the years 1948 through 1951. Since then the proponents of compulsory health insurance have given up the idea of an overwhelming blow at medicine. They have contented themselves with a slow "piece-meal" attainment of small parts. A few of these parts have been enacted. Today more than 35 million people can look to the government to pay all or part of their medical care. The Forand bill proposes to add another 13 million to this ever increasing load. In the interest of the health and well being of all Americans, medicine must defeat this type of legislation.

The Forand bill (H.R. 4700) authorizes 60 days of free hospital care or 120 days of nursing home care, with all the fringe benefits which these services afford. The government would finance the entire program. The government would control the disbursement of all funds. The government would set the rates of compensation for hospitals and physicians. Hospitals and physicians would have to conform to standards, fees, and regulations set up by the government entering into a contract with the powers to be.

Next year is a presidential election year. The A. F. L.-C. I. O. labor organization is fighting for the passage of the Forand Bill. They have a very large segment of votes. Need we know more in order to realize that there is a hard battle before us? Last

year many of the House Ways and Means Committee seemed to consider the Forand Compulsory Health Insurance bill a political football. If that was the feeling, then it must be more of a political football this year with many of the officials of the political game on its side.

Remember, the government of any nation is wholly dependent upon the people of that nation. The government does not produce anything. The people have to pay the cost, all the cost of their government. Every nation that has adopted socialized medicine has had strained financial difficulties. Look back at Germany, France, and now England. The social security structure of our own country is very top heavy. We are paying out more social security benefits than we are taking in. Each year another one fourth per cent to one half per cent is being added to wages and income. The basic taxable wages have been raised from \$4,200 to \$4,800 hiking O. A. S. I. benefits to approximately seven per cent. The Forand bill would raise the ante two billion dollars. There must be a limit to what the producing public can take. Already, today, the majority are living on the minority.

We, the medical profession, are strong enough, if we work together to win this fight. The will of the people is usually the will of the most active part of the people. With our individual contact with the people, plus our community activities we can become the "will of the people." This requires unity among ourselves; a desire to get out and work. Know thyself and let the public know your thoughts. Write your legislators frequently. They like to get friendly letters. Write them your feelings about the Forand bill. Do it today. One individual letter is sometimes worth more than group resolutions.

Eustace A. Allen, M.D.

EMORY RECEIVES GRANT

FOR THE THIRD STRAIGHT year, 20 medical schools and hospitals throughout the nation have received grants totaling \$100,000 from the Wyeth Fund for Postgraduate Medical Education.

Herbert W. Blades, president of Wyeth Laboratories, revealed that the grants are unrestricted and

that the recipients may use the funds in any way they see fit to advance the cause of medical education.

Among the institutions receiving grants of \$5,000 was Emory University.

current clinical concepts

Tumors of Lung

LIEBOW POINTED OUT that in their experience with carcinoma of the lung and bronchus in Connecticut, there has been a steady increase during the past 20 years. At present, there are four times as many cases as seen in 1935. Whereas carcinoma of the stomach has remained about the same or perhaps decreased slightly. This identical experience has been recently reported from Norway, according to him, and here the areas are primarily non-industrial. When asked about what relation cigarette smoking had to this, he told a story: "If you saw a man come out of a burning barn holding a lighted torch in one hand and a can of gasoline in the other, you might draw some conclusions as to the cause." Ratio of bronchogenic carcinoma continues 9-1, male over female.

From a lecture by Averill Liebow, M.D.
at the Atlanta Graduate Medical Assembly.

Cardiac Surgery

COOLEY HAS NOW had experience with more than 500 cases of open heart surgery. In this group he has done over 200 cases with interventricular septal defects. In this particular group there were 41 cases under the age of two years with 16 deaths or 39 per cent mortality; 11 cases from 2-15 years of age with seven per cent mortality, and in the age group from 15 years, there was a sharp increase in mortality to 50 per cent. Therefore, the ideal age is from 2-15 years. If the patient shows polycythemia and has clubbing of fingers, no surgery is recommended.

From a lecture by Denton Cooley, M.D.
at the Atlanta Graduate Medical Assembly.

Granular Urethritis in Women

LOWER ABDOMINAL PAIN and discomfort in the hips and legs may be secondary to an inflammatory process in the female urethra. If granular urethritis is found on cystoscopic examination of the urethra, fulguration of the area will result in a very high percentage of cures.

J. A. M. A., Vol. 169, No. 9 (February) 1959.

Use of Nitrofurantoin in Chronic and Recurrent Urinary Tract Infection in Children

NITROFURANTOIN HAS PROVED to be an effective and non-toxic drug when used in the treatment of urinary infection in children. However, long term therapy can safely be received with Nitrofurantoin without fear of establishing drug resistant bacterial mutants or risking undesirable side effects. Nonetheless, prolonged antibacterial therapy should be performed after complete diagnostic studies and the necessity for surgical intervention eliminated.

J. A. M. A., Vol. 169, No. 9 (February) 1959.

Intestinal Obstruction

COLE HAS ABANDONED the use of the Miller-Abbott tube because of its small lumen and tendency to become stopped up. He prefers either the Levine or single lumen tube with the mercury bag such as the Cantor for decompression. He emphasizes the necessity to keep these tubes open and in place for at least 48 hours after the patient has passed flatus.

From a lecture by Warren Cole, M.D.
at the Atlanta Graduate Medical Assembly.

Psoriasis

IN AN ARTICLE in a recent issue of the *Journal of Investigative Dermatology*, Dr. Rees B. Rees and Dr. James H. Bennett summarized their further observations in the use of Aminopterin® for psoriasis. They stressed that this drug, which interferes with the folic acid metabolism is *not* to be recommended lightly for treatment of psoriasis. Marketed in 0.5 mg. tablets, it must be given on a very rigid schedule, such as one tablet by mouth daily for six days, and repeat after a rest of one week. This drug should not be prescribed, but given directly to the patient, not more than 12 tablets at a time.

In chronic psoriasis, not relieved by the usual treatment, long term results have been good, but not spectacular. Toxicity has been high on large doses, but small doses the toxic reaction is minor, such as, sore mouth, gastrointestinal upsets, and in one patient, hair loss. Since there is a possibility of leukopenia developing, complete blood count should be done on each patient after a few weeks treatment.

Continued on page 192

CLINICAL CONCEPTS / Continued

Poison Ivy Dermatitis

IT IS TIME to warn against the use of poison ivy extracts as "shots" in the treatment of poison ivy dermatitis. No safe or adequate method has been developed which will desensitize or prevent the occurrence of poison ivy dermatitis in sensitive individuals.

Personal communication: Herbert S. Alden, M.D.

Uses of Marsilid

MARSILID HAS BEEN FOUND to be quite effective in rheumatoid arthritis, lupus, and dermatomyositis. In 75 per cent of cases steroid therapy could be sharply reduced or even eliminated slowly because of marked improvement in sense of well-being and relief of pain. The dosage is 25 mg. three times a day for one week or until improvement occurs, then 25-50 mg. after breakfast daily. If peripheral neuritis occurs, 50 mg. of pyridoxin daily will clear it promptly. This seldom occurs with doses of less than 75 mg. a day. Fatal liver damage has been reported in occasional instances but rarely is seen with the doses recommended here.

Personal communication: A. J. Merrill, M.D.

Urologic Problems in Rehabilitation of Hemiplegic Patients

URINARY INCONTINENCE, a frequent symptom following cerebrovascular accidents, may be due to impairment of cortical control or the result of co-incident urologic obstructive disease. Rehabilitation and ambulation of the patient necessitates urologic evaluation and management.

J. A. M. A., Vol. 169, No. 10 (March) 1959.

Pseudomembranous Enterocolitis

CLINICAL AND EXPERIMENTAL EVIDENCE is presented revealing pseudomembranous enterocolitis as being a complicated syndrome resulting from at least two causes: (1) formation of intracapillary fibrin thrombi in the submucosa and mucosa of the intestine, leading to infarct necrosis and pseudomembrane formation of the mucosa, and (2) staphylococcic infection, usually in the absence of normal intestinal flora and associated with antibiotic therapy.

Surgery 78:446 (March) 1959.

Observer Variation in Reports on Electrocardiogram

THE PURPOSE OF THIS PAPER was to show whether reports on electrocardiograms was subject to observer variations. A test series of 100 tracings was

selected: half had been reported to routinely show infarction, a quarter to be normal, and a quarter to show various abnormalities other than infarction. Nine experienced readers reported their opinions of the electrocardiograms on two separate occasions. They were allowed the choice of one of three reports—normal, abnormal, or infarction.

Complete agreement was reached in only one-third of the 100 tracings, majority agreement in half, but there was considerable dispute about one tracing in five. After the second reading, it was found that on average, the readers disagreed with one in eight of their original reports . . . From the standpoint of electrocardiographic diagnosis it is an illusion to believe there can be any arbitrary line between normal and abnormal tracing or between abnormal and infarction tracings. It is apparent that tracings from the intermediate zones are of little or no diagnostic value, but are very likely to be interpreted according to the clinical bias.

Brit. Heart J. 20:153, 1958.

Lister Revisited

IN A DISCUSSION referring to resistant strains of staphylococci and the increasing number of post-operative infections, the author points out that an organism gains entrance into a wound due to the let down of protective measures. The most potent sources of post-operative infections come from people. We are prone to neglect the safeguards established years ago. To prevent wound contamination, avoid fingering wounds and dressings, mask personnel properly and carry out other less spectacular but important principles of sepsis. Our aim: go back to Lister and recognize that bacteria must be kept out of wounds to avoid infection.

Surg.-Gyn. & Obs., Vol. 108:235 (February) 1959.

Vesical Neck Cicatrix

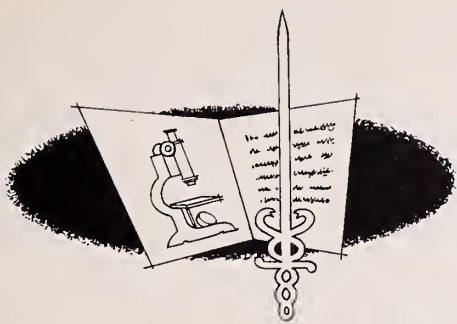
THE POPULARITY OF TRANSURETHRAL prostatic resection is almost universal, but the long term complications are somewhat less than enthusiastically recognized. One of the more serious adverse results is contracture of the vesical outlet. A similar vesical obstruction but unrelated to surgery is seen in the congenital defect, bladder neck obstruction, in infants and children. The authors have described a technique for replacing the cicatrix at the vesical neck by the use of a full-thickness bladder flap.

Surg.-Gyn. & Obs., Vol. 107, No. 6 (December) 1958.

Kanamycin

USE OF MORE than 18 grams of kanamycin may cause sudden total and permanent eighth nerve deafness.

Personal communication: A. J. Merrill, M.D.



cancer page

CANCER OF THE LUNG

IN 1942 A PROMINENT southern university graduated a group of medical students who had observed a total of two cases of lung cancer during four years of medical study. The physicians from that class now see several cases a month and one member of that group has seen over 500 patients with lung cancer during the past ten years. Cancer of the lung is a growing menace to our population. What have we accomplished in our efforts to control the disease? In 1949 reports of extensive series of cases from our large medical centers indicated five-year "cures" in from 20-30 per cent of cases which were operable. Only five years later the same institutions, headed by the same eminent surgeons, could claim results of only 10-20 per cent "cures." A portion of this apparent regression lies in the greater number of extremely anaplastic tumors which are highly unresponsive to surgical attack. Surgical methods have followed the pendulum toward first more radical pneumonectomy with block resection of mediastinal nodes and the diseased lung, and later have returned toward the less radical types of resection. A lobectomy is at present considered an acceptable approach to an early peripheral cancer without lymphatic spread. In fact, some of the highest cure rates are reported in series of limited resections. Certainly early case findings is imperative if results are to be improved. A high index of suspicion must be engendered in our population, but even more in our profession. Doctors still exhibit too much inertia in dealing with a mass in the chest—waiting for it to grow or to go away. The shortage of hospital beds, reduced priority give to major thoracic procedures because of the large amount of operating time consumed, and even the allocation by our laboratories

M. Bedford Davis, Jr., M.D., *Atlanta*

of blood to other cases which are not "elective" have caused postponement of the removal of a lung cancer for as long as a month after the diagnosis is known. A five year survival rate of 80 per cent has been obtained in a series of early cases where surgery was done within one week of the time the diagnosis was apparent.

Admittedly, our surgical treatment is inadequate and offers little hope of conquering cancer of the lung. In future years, a medical cure will doubtless be discovered, but how far off is this millinium? At the present time our predominant efforts should lie in the field of Preventive Medicine. In the twenties it was learned that chromates in crude sulfuric acid used in smelting copper led to lung cancer. It was simple to eradicate this occupational hazard completely by using less crude acid. A similar conquest has been accomplished over cases resulting from inhalation of asbestos dust. We know that one out of every ten heavy cigarette smokers will die of lung cancer—over 20,000 each year. At the same time only one out of 250 non-smokers falls a victim. The evidence is circumstantial, but very suggestive, to say the least. Indeed, it must remain circumstantial or statistical until a laboratory animal is located which will develop the type of bronchogenic carcinoma seen in man or until we agree to use man himself as the laboratory animal. Flurries of publici-

Continued on page 194

Approved by Professional Education Committee, Georgia Division, ACS.

CANCER PAGE / Continued

ty in our periodicals over the relation of smoking and lung cancer temporarily produce a minute scare in the populace, but neither this nor the lifelong crusade of men such as Alton Ochsner has prevented the steady rise of cigarette consumption in this country—together with the rise of lung cancer. It is a formidable problem and sounding an alarm serves little purpose except to increase the anxiety in smokers and perhaps to help increase their smoking. The remedy is not simple, but explanation,

education, group discussion, hypnosis, simple relaxation techniques, and alternative forms of mouth satisfaction such as sucking, chewing, or biting are helpful and, along with any other possibility which offers promise, should be energetically explored.

It would appear that primary cancer of the lung might in large measure be preventable and although prevention is difficult the situation is more hopeful than with most malignant growths.

Reference

1. Smoking, Tubercle, (Dec.) 58.

1959 CALENDAR OF MEETINGS

State

- May 17-20—Medical Association of Georgia, Augusta.
- May 17—Georgia Pediatric Society, Augusta.
- May 17—Georgia Psychiatric Association, Augusta.
- May 17—Georgia Dermatology Society, Augusta.
- May 17—Georgia Society of Anesthesiology, Augusta.
- May 17—Georgia Society of Ophthalmology and Otolaryngology, Augusta.
- May 17—Georgia Orthopedic Society, Augusta.
- May 17-18—Georgia Radiological Society, Augusta.
- May 18—Georgia Chapter, American College of Chest Physicians, Augusta.
- May 18—Georgia Urological Society, Augusta.
- May 19—Georgia OB-GYN Society, Augusta.
- May 19—Georgia Diabetes Association, Augusta.
- May 19—Georgia Academy of General Practice, Augusta.
- May 19—Georgia Chapter, American College of Surgeons, Augusta.
- May 19—Georgia Association of Pathologists, Augusta.
- Sept. 11-12—Georgia Heart Association, Savannah.
- Sept. 18-19—Georgia Tuberculosis Association, Athens.
- Sept. 18-19—Georgia Trudeau Society, Athens.
- Sept. 20—Georgia Psychiatric Association.
- Sept. 24-26—Georgia Chapter, American College of Surgeons, Sea Island.

Regional

- May 15-16—Fifth Annual Surgery, Radiology, Pathology Symposium, Oklahoma City, Okla.
- July 22-23—Rocky Mountain Cancer Conference, Denver, Colo.
- Sept. 28-29—Tennessee Valley Medical Assembly, Chattanooga, Tenn.
- Nov. 16-19—Southern Medical Association, Atlanta.

National

- April 20-24—American College of Physicians, Chicago, Ill.
- April 27-28—American Venereal Disease Association, Baltimore, Md.
- May 25-29—American College of Cardiology, Philadelphia, Penn.
- May 25-29—National Tuberculosis Association, Chicago, Ill.
- May 25-29—American Trudeau Society, Chicago, Ill.
- June 3-7—American College of Chest Physicians, Atlantic City, N. J.
- June 8-12—American Medical Association, Atlantic City, N. J.
- July 6-10—Symposium for General Practitioners on Tuberculosis, Saranac Lake, N. Y.
- Aug. 30—American Congress of Physical Medicine and Rehabilitation, Minneapolis, Minn.
- Sept. 27 - Oct. 2—American College of Surgeons, Atlantic City, N. J.
- Sept. 14-17—International College of Surgeons, Chicago, Ill.
- Oct. 3-8—American Academy of Pediatrics, Chicago, Ill.
- Oct. 23-25—American Heart Association, Philadelphia, Penn.



heart page

THE PROBLEM OF STROKES

STROKES ARE the third most frequent cause of death in the United States, exceeded only by atherosclerotic heart disease and cancer. It has been estimated that there are presently 1,800,000 stroke patients in the United States and approximately 40,000 in the state of Georgia. Fifty thousand new strokes occur each year. With our aging population, strokes will become relatively more frequent, adding to our already heavy load of chronic disease. These statistics are shocking and impressive even today when we are constantly bombarded with gruesome and morbid figures on accidents, crime, and international contention.

Strokes are most commonly caused by cerebral thrombosis, cerebral embolism, and cerebral hemorrhage. Of these cerebral thrombosis accounts for about 70 per cent of all strokes. The exact mechanism of cerebral thrombosis is unknown, but atherosclerosis and hypertension are two of the more important contributing factors. The eventual control of strokes depends upon the control of the underlying causes such as atherosclerosis, intravascular thrombosis, and hypertension. Unfortunately, control of the underlying cause or causes is not possible at the present time.

The most serious problems associated with strokes are probably not the deaths they cause but the great morbidity resulting in social, economic, and psychological problems. Following a stroke today a patient is usually hospitalized a few days for supportive care until he recovers from the period of mental confusion and coma. A rapid hospital discharge is usually made because of high hospital costs, too few hospital beds, and because there is little more that is gained by further hospital care as presently given. He is then discharged to the family's care or to a nursing home where he requires almost constant nursing care until his death. During this period

Joe E. Gahimer, M.D., *Atlanta*

of invalidism one person is needed nearly full time to care for a stroke patient.

The natural history of a stroke is that of a period of coma and mental confusion with hemiparesis. With time, the mental symptoms decrease and slowly over a period of time the involved limbs get some return of function and strength. Therefore, the natural history should be that of an acute episode with returning function over a period of time. However, during and following the acute episode, patients develop secondary deformities such as flexion contractures, decubitus ulcers, and frozen shoulders, which make the patient more of a nursing problem. Also these deformities make it impossible to use that function which does return on the involved side. The prevention of the secondary deformities alone would allow 80 per cent of these patients to care for themselves and decrease markedly the nursing care they require.

Today with improved supportive care, antibiotics, and better control of complicating diseases such as congestive heart failure, a large number of these patients live for many years and die of other conditions. This results in a serious burden upon their families both economically and socially. Not only is someone required to look after them almost constantly, but also because they are bed-fast for long periods of time and because of communicative difficulties, many of these patients become quarrelsome, obstructive, and overdemanding.

All of the above result in a loss of productive work by well family members and curtailment of

Continued on page 196

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

social activity that often contributes to intrafamily discord. Another and probably the most important facet of this problem is the unhappiness, pain, and psychological problems generated by the long periods of bedcare in the patients themselves.

In a sense the problem of strokes is an iatrogenic problem. The great advances in medicine have resulted in this large number of old people and the same advances have made it possible to keep them

alive following a stroke. Recent advances in physical medicine and rehabilitation in large centers such as those of Rusk and Buchanan now point to a more complete solution of the problems of strokes. These centers report that most stroke patients can be taught to walk and take care of their daily needs and that 30 per cent can be returned to work. The general use of these techniques in the home would result in great alleviation of the physical, social, and economic problems of strokes, and the patient's mental attitude, general health, and happiness would be much improved.

"HOW TO DRIVE AND STAY ALIVE"

DR. HARRY E. ROLLINGS was talking a lot of sense for the benefit of his fellow citizens when he spoke to the Exchange Club recently on "How to Drive and Stay Alive."

For one thing, the doctor, whose sideline is the study of automobiles and traffic safety, helped to put speed, that much-maligned element in any traffic discussion, back in its proper perspective.

Speed, to a degree, is just as much a necessity of life in today's modern scheme as the automobile itself. It must, however, be related to other factors before it can be branded as dangerous *per se*. Yet, as Dr. Rollings pointed out, virtually all traffic arrests are for speeding—hardly any for driver errors which can and *do* cause a majority of accidents.

We think the doctor is entirely right. For every accident caused by speed, we'll wager ten others are caused by the inept driver who fails to make allowances for the speed of others. You see them every day, making improper signals, turning awkwardly from the wrong lane, stopping or slowing down abruptly in the wrong place. You can't venture out into today's complex traffic on the theory that safety means you won't run into anyone else if no one else runs into you.

Our pet peeve for years has been the "when-I-stop-everybody-stops" type driver, yet the fellow never gets a traffic citation so far as we know. But the chances are you'll find him behind every instance of unnecessary congestion and a surprisingly high percentage of accidents.

Dr. Rollings has a solution that would lessen the senseless slaughter on our streets and highways, prevent countless millions of property damage, and as much to be desired by-produce, would facilitate traffic flow and eliminate much unnecessary con-

gestion. His solution involves better driver education coupled with denial of the use of streets and highways to those who patently lack the ability to drive safely and properly for one reason or another. It involves safety checks to insure the proper mechanical condition for all vehicles. It involves supplemental safety devices such as seat belts, plastic dashboards, pop-out windshields, etc.

In fact, the problem is so extensive that it is doubtful that a corrective program could ever be implemented entirely. But, we can do a great deal toward increasing safety and reducing accidents. One method is tighter restrictions on the issuance of driving permits and periodic rechecks. Another is spot checks of drivers and vehicles from a safety standpoint as a continuing police function.

This spot-check program has had considerable success in other communities, Dr. Rollings said. "The knowledge that such checks as this are being carried out regularly in a community is a great deterrent to automotive misbehavior," he declared.

With regard to enforcement, Dr. Rollings said, "It is a matter of record in the law enforcement agencies, not only here but throughout the country, that practically no citations are issued for improper turns, or lack of proper signalling, or failing to yield the right-of-way, or failing to use the proper lane. Most citations are issued for speeding or improper parking, which as we have said is not a greatly important factor in accident prevention, at least percentage-wise."

This is certainly true in Savannah. Why not start passing out a few citations of those go-slow-and-be-safe drivers who aren't about to run into anyone, but who constantly make a practice of virtually inviting other drivers to smash into them?

Savannah Morning News

president's letter

THE ASSOCIATION "YEAR" that will end next month at the Annual Session in Augusta has been one of increasing activity including one addition to the headquarters office personnel. It has been my pleasure to attend several district meetings, the meetings of Council and its Executive Committee, Committee meetings, as well as a number of special sessions, such as the Presidents and Secretaries Conference in Atlanta in February.

In March I attended the regional Medical-Legal Conference in Washington, D.C., sponsored by the AMA.

There is one committee with which I have been particularly concerned, and that is the newly formed "Medical Technology Liaison Committee." This group has held two meetings recently. It is my hope that this committee will become a permanent group functioning as a liaison between the Georgia Hospital Association, the Georgia Association of Pathologists, the Georgia Society of Medical Technologists, and MAG. It has been generally agreed that each of these organizations should have two representatives serving a term of three years each.

It has been recommended that the purpose of this proposed Medical Technology Liaison Committee should be (1) to improve the status and quality of technologists and (2) to improve the quantity of technologists in Georgia to alleviate the current shortage.

This will be my last President's Letter and I would like to thank all those who have worked on MAG Council and Committees toward the betterment of the Association. It has been a great honor to serve as your President. I am looking forward to serving on the Executive Committee and Council as your Immediate Past President next year.



Lee Howard, Sr., Savannah

Lee Howard Sr. M.D.

President, Medical Association of Georgia



the association

MEDICARE CONTRACT RENEGOTIATED

THE MEDICAL ASSOCIATION OF GEORGIA has renegotiated the Medicare Contract with the Department of Army up to the period March 1, 1960, with all previous provisions remaining the same.

With two exceptions, the maximum fees allowable under the Program are also unchanged. In order to make the Cesarean section fees more in accord with normal medical practice charges in Georgia and to meet the economic needs of the Program, the maximum fees allowable for Code 4801, Classic Cesarean section, and Code 4802, Low cervical Cesarean section, have been adjusted to \$150.00 and \$175.00, respectively. These fees are exclusive of the fees allowable for ante-partum and post-partum care. The fees were effective March 15, 1959.

The proposed changes to the contract regarding the present provisions that (1) a physician rendering obstetrical care on an out-patient basis may bill for necessary parenteral drugs at cost only, not at his normal charge, and that (2) when the delivering physician renders normal hospital newborn care he may charge only 50 per cent of the maximum fee allowable for such care when rendered by other than the delivering physician met with negative results.

Several physicians had requested that a flat fee of \$3.00 be allowed for any parenteral injection, and that the ruling in regard to newborn care be modified or eliminated in order to allow the maximum fee to any physician who normally so charges. The Medical Association of Georgia endorsed these recommendations and forwarded them to the Department of Army for their approval.

The Government's refusal to change these provisions per our request was based on the fact that (1) no other state appeared dissatisfied with these provisions and had raised no such objections and (2) due to the budgetary limitations it was impossible to increase the cost of the program or effect a change which, in itself, would necessitate additional expenditures.

The restrictions made effective October 1, 1958, which were necessary for budgetary reasons, have decreased the Medicare claim volume in Georgia to about 30 per cent of the pre-restriction volume. The possibility of the program being reinstated to its previous coverage appears remote at the present time, as it seems Congress is looking for additional areas to economize in Medicare.

ANNOUNCEMENTS

At the Annual Meeting of the Metropolitan Committee on Alcoholism to be held May 9 at the Henry Grady Hotel, Dr. Marvin Block of Buffalo, N. Y. will be guest speaker. A contribution of \$3.50 will cover the cost of the entire meeting including lunch. Reservations and tickets are available at the office of Mrs. Callye Neese, Georgian Clinic, 1260 Briarcliff Road, N.E., or phone TRinity 5-8373.

The Medical College of Georgia and Medical College of Georgia Foundation, Inc. announce a clinical workshop on "The Ill Newborn Infant," May 26, 27, and 28, in Augusta. The fee is \$25.00. Course will be limited to 20 physicians. Application has been made to the American Academy of General Practice for Credit I, 16 hours. For further information write: Dr. Claude-Starr Wright, Department of Continuing Education, Medical College of Georgia, Augusta, Georgia.

The Department of Otolaryngology, University of Illinois College of Medicine, announces two special postgraduate courses to be offered in the fall of 1959: Annual Otolaryngologic Assembly, September 18-26 and Course in Laryngology and Bronchoesophagology, November 9-21. Interested physicians should write direct to the Department of Otolaryngology, 1853 West Polk Street, Chicago 12, Illinois.

The American College of Physicians announces Postgraduate Course No. 3, May 22-24, Philadelphia; Postgraduate Course No. 4, June 1-5, Baltimore; Postgraduate Course No. 5, June 15-19, Denver; and Postgraduate Course No. 6, June 22-26, Cincinnati. The topics for these courses will be "Cardiac Arrhythmias," "Psychiatry for the Internist," "Special Topics in Internal Medicine," and "Internal Medicine: Selected Topics," respectively. For additional information write: Executive Offices of The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

SOCIETIES

At a recent meeting of the BIBB COUNTY MEDICAL SOCIETY, Dr. Henry W. Brosin, nationally known psychiatrist and chairman of the department of psychiatry at the University of Pittsburgh Medical School, delivered the annual Witman Memorial Lecture.

J. M. Byne, Jr. of Waynesboro has been re-elected

to the board of directors of Physicians Service, Inc. for a three-year term to represent the BURKE COUNTY MEDICAL SOCIETY.

R. H. Randolph, Marion A. Hubert, and J. B. Traylor all of Athens are representatives of the CRAWFORD W. LONG MEDICAL SOCIETY on the Blue Shield Board of Directors.

Albany was the site for the third annual Southwest Georgia Medical Seminar, sponsored by the DOUGHERTY COUNTY MEDICAL SOCIETY last month.

The Atlanta Graduate Medical Assembly held at the Biltmore Hotel in Atlanta recently is annually sponsored by the FULTON COUNTY MEDICAL SOCIETY.

Dr. George Morris of the Baylor University Medical School, Waco, Texas, addressed members of the GEORGIA MEDICAL SOCIETY at their regular meeting.

THE MUSCOGEE COUNTY MEDICAL SOCIETY met recently and had as their speaker, Dr. George Cooper, Jr., professor of radiology at the University of Virginia, who spoke on "Cancer of the Lung."

Dr. and Mrs. Homer P. Woods entertained the SOUTHWEST GEORGIA MEDICAL SOCIETY at the American Legion Hall. The speaker for this meeting was Clarence Bridges, pathologist from Albany.

Dr. G. Kekle Taylor, an eye, ear, nose, and throat specialist from Jacksonville, Fla., spoke to the WARE COUNTY MEDICAL SOCIETY recently. The meeting was held at the Okefenokee Golf Club.

DEATHS

THOMAS PONDER BROWN, 78, died at his home in Grady County February 22 after a lengthy illness.

Dr. Brown attended the University of Georgia and at one time was a principal of a Grady County school. He received his medical degree from the University of Georgia School of Medicine in Augusta.

He practiced medicine in Augusta for 35 years before retiring and returning to Grady County. He was a Mason, Woodman of the World, and a member of Beth Page Methodist Church in Grady County. During World War I he served as a captain in the Medical Corps.

Survivors include his wife; three daughters, Mrs. K. W. Shull, Baton Rouge, La., Mrs. William S. Swain, Denver, Colo., and Mrs. S. H. Welch, Grady County; one brother, C. H. Brown, Grady County; nine grandchildren; and several nieces and nephews.

DANIEL SPENCER MIDDLETON died February 8 at his home in Rising Fawn at the age of 88.

Dr. Middleton attended schools in Mississippi and was graduated from U. S. Grant University Medical School. In 1913, 1914, and 1937 he was active in the Georgia House of Representatives and in 1914 he was responsible for the Middleton-Ellis Health Law. He was also Dade County's Senator in the 44th District during 1925 and 1926.

He was honored following 50 years of service when the Medical Association of Georgia presented him a Certificate of Distinction. In 1953 he received a life membership award from the Medical Association of Georgia. He was a member of the Rising Fawn Baptist Church and served as a member of the Board of Deacons.

Survivors include his wife; one daughter, Mrs. George Bailey, Columbus, Miss.; one son, Spencer Hale Middleton, Rising Fawn; a sister, Mrs. Lucy Dunn, Lula, Miss.; and two brothers, W. J. Middleton and R. L. Middleton, Gore Springs, Miss.

HAL CURTIS MILLER, 71, died February 27. Born in West Point, he attended Emory College and received his medical degree in 1909 from Jefferson Medical College, Philadelphia.

A fellow of the American College of Surgeons, Dr. Miller was also a life member of the Fulton County Medical Society, the Medical Association of Georgia, and the American Medical Association. He was a member of the Piedmont Driving Club, the Kiwanis Club, the Phi Chi medical fraternity, and the Alpha Tau Omega social fraternity. Dr. Miller was on the staffs of Emory, Georgia Baptist, St. Joseph's, and Crawford Long hospitals. He was also a member of the Peachtree Road Methodist Church.

Survivors include his wife; two sons, Hal C. Miller, Jr., Barre, Vt. and Henry D. Miller, Atlanta; and a sister, Mrs. Ola M. Johnson, West Point.

LEHMAN W. WILLIAMS, Savannah, died at the age of 71, January 28 after a short illness.

A graduate of Emory University and Jefferson Medical School of Philadelphia, he would have been a practicing physician 50 years in May. Dr. Williams was a member of the Georgia Medical Society, a life member of the American Medical Association, and a member of the Southern Medical Association and the Surgical Congress.

A past president of the Lions Club, he was a life member of the Elks and a member of the Solomon's Lodge, Alee Temple, a past patron of the Bethlehem Chapter No. 269, Order of the Eastern Star.

Dr. Williams was a member of the Chamber of Commerce and of St. Paul's Lutheran Church. He served in the Medical Corps in World War I.

Survivors include his wife; two daughters, Mrs. Sam Gay, Ft. Pierce, Fla. and Mrs. William W. Quinn, Washington, D. C.; a son, Lehman W. Williams, Jr., Memphis, Tenn.; one brother, George Williams, Douglas; a sister, Mrs. James Holland, Macon; seven grandchildren; and a number of nieces and nephews.

PERSONALS

First District

C. T. BROWN, is in Savannah for a three months orientation at the Chatham County Public Health Department.

At the annual meeting of the Alabama Chapter of the American College of Surgeons held at Point Clear, near Mobile last month, JULIAN K. QUATTLEBAUM delivered a lecture.

EDWIN SHEPHERD attended the two-day conference on the medical problems involved in treating patients with arthritis and birth defects in New Orleans recently.

PETER L. SCARDINO took part in a panel discussion at a regional meeting of the American College of Surgeons in St. Louis last month.

Second District

No news submitted.

Third District

FRANK A. WILSON, III, has passed requirements for his admission as a specialist to the American Board of Internal Medicine.

LEONARD T. MAHOLICK delivered the keynote address before the Community Mental Health Center workshop held in Topeka, Kansas.

Fourth District

No news submitted.

Fifth District

The main speaker for the Board of Directors meeting of the Northeast Georgia Chapter of the Heart Association was ELBERT P. TUTTLE, JR.

JOSEPH C. MASSEE, internist and past-president of the Georgia Heart Association, spoke recently to the Pilot Club and their guests.

BYRON M. HARPER, JR., was guest speaker at the East Point Lions Club.

A program on "Heart", sponsored by the Georgia Heart Association, was presented by the Better Health Council at the Douglas County Health Center last month, J. GORDON BARROW, serving as principal speaker.

VERNELLE FOX gave a talk on alcoholism before the Decatur Kiwanis Club at one of their recent meetings.

The doctors division of the Georgia Heart Association fund drive met recently at the Mayfair Club. J. WILLIS HURST and ELBERT P. TUTTLE were guests of honor at the reception.

DR. and MRS. A. H. LETTON attended the Southeastern Surgical Conference held in Miami last month.

Sixth District

ROY WILLIAMS and WALTER J. REVELL were among the doctors that attended the Conference of Physicians in Atlanta.

Seventh District

One of the guest speakers at a recent meeting of the B & PW Club of the YMCA was ERNEST THOMPSON.

Eighth District

C. A. WILSON, JR., VILDA SHUMAN, and G. J. AUSTIN, JR., recently returned from New Orleans where they attended a two-day conference on the medical problems involved in treating patients with arthritis and birth defects.

Ninth District

RAYMOND D. EVANS, SR., has resigned as chairman of the State Medical Education Board.

The Buford Jaycees, with the help of HARRY HUTCHINS, STERLING HARRIS, and CECIL MILLER, sponsored a Polio Clinic in Buford recently.

Tenth District

E. V. HASTINGS has been named president of the medical staff at St. Joseph Hospital.

The program for the Georgia Conference on Social Welfare was presented by FLOYD BLIVEN, VICTOR C. VAUGHAN, III, WILLIAM MORETZ, and JOHN KEMBLE.

CORBETT H. THIGPEN, co-author of "The Three Faces of Eve," spoke on "Hypnosis" to the North Georgia College student body during one of their recent assembly meetings.

ADDISON W. SIMPSON, JR. was presented an award for outstanding service in the fight against heart disease at the 1959 Heart Fund kickoff dinner held last month.

JACK H. LEVY received the honorary degree of Fellow in the American College of Radiology at a recent meeting in Chicago.

BOLLING S. DuBOSE, JR. attended the two-day conference held in New Orleans on the medical problems involved in treating patients with arthritis and birth defects.

EXECUTIVE COMMITTEE OF MAG COUNCIL MEETING

CHAIRMAN GEORGE R. DILLINGER called the Executive Committee of MAG Council to order at 7:15 A.M., February 15, 1959 in Room 1012, Atlanta Biltmore Hotel, Atlanta, Georgia.

Executive Committee of Council members present including the Chairman were: Lee Howard, Sr., Savannah, President; Luther Wolff, Columbus, President-Elect; W. Bruce Schaefer, Toccoa, Immediate Past President; Chris J. McLoughlin, Atlanta, Secretary-Treasurer; J. G. McDaniel, Atlanta, Chairman of the Finance Committee. Also present were J. Frank Walker, Atlanta, Chairman of the Legislation Committee; T. A. Peterson, Savannah, 1st District Vice-Councilor; Edgar Woody, Jr., Atlanta, Editor, *Journal of the Medical Association of Georgia*; Mr. Leo Brown, Chicago, Director, AMA Communications Division; Mr. Frank Shackelford, General Counsel for MAG; Mr. Milton D. Krueger, Mr. John F. Kiser, and Mrs. Emily Grinalds of the Headquarters Office Staff.

Chairman Dillinger gave the Invocation.

MINUTES—Mr. Krueger read the minutes of the December 13-14, 1958 Council meeting for the information of the Executive Committee. Finance Committee Chairman, J. G. McDaniel pointed out that it is hoped that the \$1500 appropriation for the Crawford W. Long Memorial will be sufficient.

FINANCE COMMITTEE REPORT—Chairman McDaniel gave the Finance Committee report for January which was approved as presented.

JOURNAL REPORT—Journal Editor, Edgar Woody, Jr., reported that the change in Managing Editors has been accomplished in a smooth manner. He called attention to the plan of increasing the prominence of the cover picture to cover the entire page and stated that the flag has been made smaller in order to accentuate the cover picture. The advertising outlook for 1959 looks considerably better than 1958 stated Dr. Woody. He said the Journal plans to carry more and better scientific articles than ever before. This report was accepted for information with the thanks of the Committee.

HEADQUARTERS OFFICE REPORT—Mr. Krueger reported that the Staff of the Headquarters Office has increased its efficiency and is appreciative of the leadership given by the Executive Committee of MAG Council.

(a) Blue Cross Employee Plan Changes—On motion (Schaefer-McDaniel) it was voted that the proposed preferred Blue Cross Plan be approved by the Executive Committee and that the policy changes be referred to MAG Council for action.

(b) Membership Clarification—Mr. Krueger read a letter from the Secretary of the Bibb County Medical Society asking clarification of three members of the Society who are in service, but continue a limited private practice and who request exemption from paying dues. This matter was referred to the Constitution and By-Laws Committee of MAG, who will be advised by

the General Counsel. Mr. Krueger was instructed to write a letter to Bibb County advising them of the Executive Committee's action on this matter.

(c) Specialty Listing in Roster—Mr. Krueger reported that \$500 was saved on the 1959 Roster and there would be a saving of \$700 the following year. Mr. Krueger read a letter from Dr. Wm. C. Retterbush, Valdosta, suggesting that a doctor's specialty, if Board certified, be noted with an asterisk after his specialty in the Roster. This matter was referred to MAG Council at their next meeting and it was suggested by the Executive Committee that each County Society specify what each member's specialty is.

(d) Annual Session—Mr. Krueger reported that there are no problems at this time on this matter. Everything is scheduled but the President's Banquet. On motion (Schaefer-McDaniel) this report was accepted for the information of the Committee.

BUILDING COMMITTEE REPORT—Secretary McLoughlin reported on status and activity of the Building Committee. On motion (Schaefer-McDaniel) it was voted that the building problem be tabled for the time being and that the Building Committee continue looking for other locations.

LEGISLATION REPORT—Chairman Walker and Mr. Kiser reported that the Legislation Committee has been very active this year and that there is no way to plan action ahead as each General Assembly is different. General Counsel Shackelford commented on the importance of personal contact between doctors and their legislators. On motion (McDaniel-Schaefer) it was voted to commend the Legislation Committee on its activity and to accept the report for information. President-Elect Wolff suggested that MAG initiate a counter-offensive against cults, after a conference with General Counsel Frank Shackelford. It was recommended that this matter be brought before MAG Council and placed on the Agenda with recommendations from the Legislation Committee and Mr. Shackelford.

COUNTY SOCIETIES COMPLAINTS CONCERNING SCHOOL INSURANCE—Mr. Krueger read letters from four county societies concerning complaints against two insurance companies regarding claims. This matter was referred to the Insurance and Economics Committee and the General Counsel.

FLORIDA AND ALABAMA FRATERNAL DELEGATES—Mr. Krueger read a letter from the Medical Association of the State of Alabama telling of their annual meeting on April 9-11 requesting the name of MAG fraternal delegates. On motion it was voted to list Chris J. McLoughlin, M.D., Atlanta as delegate with Luther Wolff, M.D., Columbus as alternate. A letter from the Florida Medical Association concerning their annual meeting on May 3-6 was read and on motion it was voted to list J. W. Chambers, LaGrange as delegate with Lee Howard, Sr., M.D., Savannah as alternate.

PODIATRY REQUEST—Secretary McLoughlin read a letter from the Georgia Podiatry Association stating that they would be glad to appear before the Executive Committee of Council. General discussion ensued. On motion (Wolff-McDaniel) it was voted to invite the Georgia Podiatry Association to attend the March 7-8 meeting of MAG Council. President-Elect Wolff was requested to furnish certain background data and the Headquarters Office was directed to send this information to members of MAG Council one week in advance of March 7, 1959.

APPROVAL OF KEYMAN FOR NATIONAL LEGISLATION—On motion (Schaefer-McDaniel) it was unanimously voted to renominate Eustace Allen, Atlanta, to the National Legislation Committee.

MEDICAL LEGAL MEETING, MARCH 20-21, 1959, WASHINGTON, D. C.—Mr. Krueger read a letter from AMA concerning this meeting and President Lee Howard, Sr. announced that he had accepted the invitation to attend this Conference. On motion (Wolff-Schaefer) it was voted that the Executive Committee approves MAG Legal Counsel attending this meeting and that funds be appropriated from the contingent funds for this matter. Mr. Krueger was instructed to place this on the Agenda for the March MAG Council meeting.

COOK COUNTY MEDICAL SOCIETY REQUEST—This matter was previously discussed by MAG Council regarding four members who wish to form a Society. A letter was read from F. G. Eldridge, Valdosta, who investigated the problem stating that Berrien County would like to form a new Medical Society along with Cook County. This matter was referred to the next meeting of Council for approval. Mr. Krueger was instructed to write them of this action. On motion (Schaefer-McDaniel) it was voted to recommend to the Constitution and By-Laws Committee that the Constitution be changed to read 10 members shall form a Society instead of three.

AMA REQUEST RE: MEDICAL CARE PLAN—Mr. Krueger read a letter from the AMA from F. J. L. Blasingame, M.D. stating that they want the opinion of the State Associations prior to the June AMA House of Delegates meeting to adopt the recommendation of the Reference Committee on Insurance and Medical Service. It was voted that this matter be referred to the Insurance and Economics Committee and that Chairman Thomas study the matter and bring a resume to the March 7-8 MAG Council meeting. Mr. Krueger was instructed to notify Council that this matter is pending.

NATIONAL HEALTH FORUM, MARCH 17-19, CHICAGO, ILL.—Mr. Krueger reported that Chairman of the Committee on Industrial Health, T. A. Peterson, Savannah, has been invited to attend the 1959 National Health Forum in Chicago, March 17-19. On motion (Wolff-McDaniel) it was voted that the Executive Committee recommend to MAG Council that funds be appropriated to send T. A. Peterson to this meeting, the expenses to come from the contingent funds. Mr. Krueger was instructed to add this to the Agenda of the March Council meeting.

APPOINTMENT TO WEEKLY HEALTH COLUMN COMMITTEE—On motion duly made and seconded it was voted that Chairman H. C. Derrick, LaFayette, suggest the name of a Pediatrician to serve on this Committee and so notify the Executive Committee.

HOSPITAL COMMITTEE LETTER—Mr. Krueger read a letter from Chairman Milford B. Hatcher, Macon, concerning a recommendation of the Hospital Committee pertaining to County Medical Society approval of Hill-Burton facilities. On motion (Schaefer-McDaniel) it was voted that Hospital Committee Chairman Hatcher attend MAG Council meeting in March and further clarify, with evidence, this directive if he wishes to use the name of the Council in the letter.

RURAL HEALTH COMMITTEE REPORT—Mr. Krueger read a report of the Rural Health Committee of MAG meeting of February 1, 1959. This report was accepted for information on motion (McDaniel-Schaefer) and the Committee was commended for its efforts.

DATE AND SITE OF NEXT MEETING—It was unanimously voted to hold, if necessary, the next meeting of the Executive Committee of Council following the March 7-8 meeting of MAG Council in Brunswick.

OLD BUSINESS—Chairman Dillinger relinquished the Chair to Vice-Chairman McDaniel and the following proposal was made by him: That the Executive Committee designate the Executive Secretary to carry out the duties set forth in Chapter 6, Section 4 in the By-Laws since he is charged by the By-Laws with operating the Headquarters Office. On motion (Wolff-Dillinger) it was voted to refer this proposal to the Constitution and By-Laws Committee for interpretation and clarification with the aid of the General Counsel.

NEW BUSINESS—Concerning the meeting place of the Council of MAG, it was voted on motion (Schaefer-Wolff) that the Executive Committee recommend to MAG Council that every other Council meeting will be held in Atlanta and that Council not go back to places they have met within two years. There was discussion about Council meeting at Callaway Gardens after the meeting to be held during the Annual Session in May in Augusta. Mr. Krueger was instructed to place this matter of Council meetings in the future on the Agenda for MAG Council in March.

ADJOURNMENT—There being no further business the meeting was adjourned at 10:15 A.M.

MEDICAL ASSOCIATION OF GEORGIA HOSPITAL RELATIONS COMMITTEE

CHAIRMAN MILFORD HATCHER, Macon, called the meeting of the Hospital Relations Committee of the Medical Association of Georgia to order at 8:00 P.M., February 15, 1959 in Room 1016 of the Atlanta Biltmore Hotel, Atlanta, Georgia.

Members of the Committee present included Milford Hatcher, Macon, Chairman; David Henry Poer, Atlanta, Co-Chairman; P. W. Wurga, Athens; H. C. Derrick, LaFayette; Fred Simon-ton, Chickamauga; Kirk Shepard, Thomasville; A. W. Simpson, Washington; and W. L. Pomeroy, Waycross.

Also present was John Mauldin, Atlanta and Warren S. Dorough, Atlanta. Mr. M. D. Krueger, MAG Executive Secretary was also present.

Chairman Hatcher called on Mr. Krueger to read the minutes of the April 13, 1958 Hospital Committee meeting and these minutes were approved as read with the correction that the State Board of Health should read State Department of Health and Hospital Services Division.

the association CONTINUED

PARAMEDICAL RECRUITMENT—Chairman Hatcher and Mr. Krueger reviewed the paramedical recruitment problem and discussion ensued concerning Mrs. Dorothea Porter and her program in Savannah. This matter was received for information.

HILL-BURTON ACTIVITIES—Dr. Hatcher discussed the activity of the State Department of Health, Hospital Services Division, in obtaining consent and/or approval of the County Medical Society before initiating Hill-Burton projects over the state of Georgia. Dr. Hatcher read a rough draft of a letter to be sent to all county medical societies on this subject. The latter was discussed and it was moved (Poer-Derrick) that the Hospital Committee of the State Board of Health be requested to issue a directive to the Hospital Services Division of the Department of Public Health that the final approval of any project to be constructed under the Hill-Burton Act by this Committee not be given until after the site and final construction plans have been approved by a majority of members of the local county medical society (present and voting after ten days advance notice) or a majority of the doctors in the area involved as determined by the Hospital Committee of the Board of Health. The motion further stated that a copy of this action should be forwarded to the Chairman of the Hospital Committee of the Board of Health. The Motion further stated that a copy of this action should be forwarded to the Chairman of the Hospital Committee of the State Board of Health as soon as possible. This motion was approved.

It was also moved (Warga-Pomeroy) that the letter to the county medical society secretaries discussed by Mr. Hatcher be forwarded as soon as possible.

GEORGIA HOSPITAL-MEDICAL MEDIATION COUNCIL—Chairman Hatcher discussed the purpose, operation, and composition of the Georgia Hospital-Medical Mediation Council. Dr. Hatcher then called on John Mauldin who explained certain proposed professional standards for the hospitals of Georgia.

On motion (Warga-Simpson) it was voted that the Association Hospital Committee approve the report of the Georgia Medical Mediation Education Committee on Professional Standards for Hospitals as given by Dr. John Mauldin and further action be taken to implement and supplement this program of hospital standards approval beginning in the year 1960.

NURSES COMMISSION REPORT—Chairman Hatcher called on W. S. Dorough of Atlanta, member of the Governor's Nurses Commission who reported on the findings of this Commission. On motion (Simpson-Poer) it was moved and voted that the Hospital Committee of the Association approves the report of the Georgia Commission on Nursing and requests the MAG House of Delegates approval of this report and it's being referred back to the Hospital Committee for action. The motion further stated that this Georgia Commission on Nursing report be presented to the AMA House of Delegates by the AG-AMA Delegates.

PHYSICIAN-INSTITUTION RELATIONS—Chairman Hatcher discussed the action of the Association's Committee on Physician-Institution Relations and this data was received for information.

Chairman Hatcher called for old business and there being none then called for new business and on motion duly made and seconded it was aged that the next meeting of the MAG Hospital Relations Committee would be held June 14, 1959 at the site of Fred Simonton's Farm, Centralhatchee, Georgia.

The meeting adjourned at 10:35 P.M.

MAG MATERNAL AND INFANT WELFARE COMMITTEE

THE MEETING OF THE Medical Association of Georgia Maternal and Infant Welfare Committee was called to order by Chairman Eugene Griffin, Atlanta at 11:15 A.M., Sunday, February 22, 1959 at the Academy of Medicine, Atlanta, Georgia.

Committee members present included Louella Kline, Atlanta; Helen Bellhouse, Atlanta; Hugh Bickerstaff, Columbus; Peter Hydrick, College Park; C. I. Bryans, Jr., Augusta; Albert G. LeRoy, Thomson; and Chairman Eugene Griffin, Atlanta.

Also present was Mrs. Jeanette Bowman and M. D. Krueger of the Headquarters Office Staff.

Chairman called on Mr. Krueger to read the minutes of the

Maternal and Infant Welfare Committee meeting, April 27, 1958 which were approved as read.

MID-WIFE DELIVERY APPROVAL—It was unanimously recommended by the Committee to Dr. Louella Kline that "when improper approval for mid-wife delivery is noted, that the Committee be notified and if the Committee agrees with this finding, that the physician involved be so notified."

REVISED BIRTH CERTIFICATE—Chairman Griffin discussed the new revision of the Georgia birth certificate as revised by the Bio-statistics Division, State Department of Health. It was noted that there had not been adequate consultation with the Maternal and Child Health Division of the State Department of Health and the Medical Association of Georgia. General discussion ensued. On motion (Bickerstaff-Hydrick) it was voted that the Maternal and Infant Welfare Committee of the Medical Association of Georgia disapproves of the newly adopted birth certificate form and that Dr. T. F. Sellers, Director of the Georgia State Department of Health and Dr. Fred Simonton, Chairman of the Georgia State Board of Health be so notified. The motion further stated that the Committee would favor a more simplified form than the old one with respect to the medical information, but feels that the abysmal lack of any medical information on the present form is a serious handicap to the Medical Association of Georgia Committee. The Committee further requested a new form be devised or an addition to the present form which would include certain basic medical information and further that the Committee would be glad to cooperate in deliberation to this end.

MATERNAL AND INFANT WELFARE COMMITTEE BUDGET—It was unanimously agreed by the Committee that two copies of the book "Perinatal Loss in Modern Obstetrics" by Nesbit (\$12.00 each) be purchased and these books sent to Drs. Griffin and Sharpley. It was further recommended, if the Chairman so desires, that the Association should buy additional copies of this book for distribution to members of the Committee at the Chairman's request.

APPRECIATION TO DR. MULHERIN—It was unanimously recommended that the Chairman of the Maternal and Infant Welfare Committee write a letter of appreciation expressing the Committee's sentiment to Dr. Mulherin for a job well done as former Chairman of the Committee.

REPEATS ON MATERNAL DEATHS—The problem of the same physician repeatedly reporting maternal deaths was discussed by the Committee and the Committee decided to devote a special meeting to the review of individual cases in this category.

DATE AND SITE OF NEXT MEETING—By general agreement it was recommended that the Committee meet at 11:00 A.M., April 19, 1959 in the MAG Headquarters Office, Academy of Medicine, Atlanta, Georgia.

CASE REPORTS—The Chairman then called for case reports to be reviewed by the Committee and the Committee recommendations were made in each of the cases so reported.

The meeting was adjourned at 4:30 P.M.

WEEKLY HEALTH COLUMN COMMITTEE

CHAIRMAN H. C. DERRICK, LaFayette, called the meeting of the Weekly Health Column Committee to order at 7:20 P.M.

Present, including the Chairman were: Jule C. Neal, Jr., Macon; August S. Yochem, Jr., Atlanta; Lamar F. Glass, Atlanta; T. J. Vansant, Jr., Marietta; Mrs. Bob Christian, Atlanta; and Mrs. Emily Grinalds of the Headquarters Office Staff.

Chairman Derrick introduced a new member of the Weekly Health Committee, T. J. Vansant, Jr., Marietta.

The following articles were approved for release:

Electroshock Treatment Often Helps.

Kidney Stones Must Be Passed or Removed.

Best Boil Protection Is Health and Cleanliness.

Why Not Breast Feed Your Baby?

Adopted Child, Like All Children, Needs Love.

Crawford W. Long.

Chairman Derrick read a letter that he has written to T. A. Sappington, M.D., Thomaston, Georgia. The letter is as follows:

"It is requested by me and the other doctors that are on my committee writing "Doc MAG Says," which are medical articles of interest to the public that appear in the weekly newspapers of Georgia on a volunteer basis, sponsored by the Medical Association of Georgia, that we be given some credit on hours of training to meet our GAGP requirement of post graduate study.

Please give this your consideration and if further information is needed I will be glad to furnish same."

The following articles were discussed:

Mental Sickness Shouldn't Be Hidden . . . Yochem
Cysts Derrick
Cancer of the Cervix Neal
Article to be Sent In Glass
New subjects to be discussed at the next meeting are:
Boredom and Fatigue Yochem
Peptic Ulcer Vansant
Cancer of the Rectum Glass
Care of the Aged Derrick
Anesthesia in Childbirth Neal

Chairman Derrick requested that members unable to attend the Weekly Health Column Committee meeting send in their articles any way. They will be discussed at the meeting and given to Mrs. Bob Christian for editing.

There being no further business, the meeting was adjourned at 9:20 P.M.

MEDICAL ASSOCIATION OF GEORGIA COUNCIL MEETING

THE MARCH MEETING of the Council of the Medical Association of Georgia was called to order at 2:10 P.M., Saturday, March 7, 1959 at the King and Prince Hotel, St. Simons Island, Georgia by Chairman George Dillinger, Thomasville.

Present in addition to the Chairman were Lee Howard, Sr., Savannah, President; Luther Wolff, Columbus, President-Elect; George Alexander, Forsyth, Vice-President; Chris J. McLoughlin, Atlanta, Secretary-Treasurer; Thomas W. Goodwin, Augusta, Speaker of the House; Charles T. Brown, Guyton, 1st District Councilor; T. A. Peterson, Savannah, 1st District Vice-Councilor; George R. Dillinger, Thomasville, 2nd District Councilor; W. G. Elliott, Augusta, 3rd District Councilor; Willis P. Jordan, Columbus, 3rd District Vice-Councilor; Virgil Williams, Griffin, 4th District Councilor; J. G. McDaniel, Atlanta, 5th District Councilor; Charles S. Jones, Atlanta, 5th District Vice-Councilor; Henry H. Tift, Macon, 6th District Councilor; D. Lloyd Wood, Dalton, 7th District Councilor; Ralph W. Fowler, Marietta, 7th District Vice-Councilor; F. G. Eldridge, Valdosta, 8th District Councilor; James M. Hicks, Brunswick, 8th District Vice-Councilor; C. R. Andrews, Canton, 9th District Councilor; A. W. Simpson, Jr., Washington, 10th District Councilor; David R. Thomas, Jr., Augusta, 10th District Vice-Councilor; Eustace A. Allen, AMA Delegate; J. W. Chambers, LaGrange, member of Council Committee on Reorganization; Mr. Frank Shackelford, Atlanta, MAG General Counsel; Edgar Woody, Jr., MAG Journal Editor; Mr. Milton D. Krueger, Mr. John F. Kiser and Mrs. Emily Grinalds of the MAG Headquarters Office.

Following the invocation given by Dr. Dillinger, the minutes of Council's December 13-14, 1958 meeting and Executive Committee minutes of December 14, 1958 and February 15, 1959 were read by Mr. Krueger. On motion (Wood-Howard) it was voted that all minutes be approved as read.

COOK-BERRIEN COUNTY SOCIETY REQUEST—F. G. Eldridge, 8th District Councilor, brought up the matter of the Cook-Berrien County Medical Society request for a charter from MAG Council. After discussion, it was voted (Alexander-Wood) that Cook-Berrien Society's request for a charter be granted when they have complied with the MAG Constitution and By-Laws.

REPORT OF FINANCE COMMITTEE—J. G. McDaniel, Chairman of MAG Finance Committee, presented the monthly budget report of the Finance Committee and also a tentative statement of income and expense for the year 1958. On motion (Wood-Peterson) the tentative statement of income and expense for 1958 was approved as presented by Dr. McDaniel. On motion (McDaniel-Wood) the monthly budget report was approved.

SPECIALTY DESIGNATION IN MAG ROSTER—The matter of listing a physician's specialty with an asterisk if board certified in the MAG Roster was discussed. On motion (Jordan-Williams) it was voted that Roster listings be continued as in the past.

FUTURE COUNCIL MEETING SITES—Mr. Krueger brought up the recommendation of the Executive Committee that every other Council meeting be held in Atlanta and that Council not return to places they have met within two years. Chairman Dillinger then ruled that since only one more meeting of Council is to be held and its place is fixed (Augusta), that Council cannot bind the 1959-60 Council and the Chairman therefore ruled this item out of order.

Dr. Wood invited the Council to meet in Dalton and this item will be placed on the agenda for the organizational meeting of the 1959-60 Council.

HEADQUARTERS OFFICE REPORT—Mr. Krueger presented a request for representatives of the Association to attend meetings and the following action was taken: On motion (McDaniel-Howard) it was voted that expenses be approved for Dr. T. A. Peterson to attend the National Health Forum meeting, March 17-19, in Chicago. On motion (Alexander-Wood) expenses were approved for MAG General Counsel Frank Shackelford to attend the AMA Medical-Legal meeting, March 20-21, Washington, D. C.

BLUE CROSS EMPLOYEE PLAN CHANGES—Mr. Krueger presented the recommendation of the Executive Committee in regard to changing the present Blue Cross-Blue Shield coverage of MAG Headquarters Office employees. On motion (Peterson-Wood) it was voted that the new "preferred plan" be approved for MAG employees.

BIBB COUNTY MEMBERSHIP PROBLEM—Mr. Krueger explained the background of this problem which involves whether or not active duty physicians in the armed forces who are doing some private practice should be considered dues paying members of the Association. After discussion, it was voted on motion (Wolff-McDaniel) to approve the interpretation in the By-Laws made by MAG Legal Counsel in regard to dues status for M.D.'s on active duty in the service which designates such members as dues-paying.

ACTIVITY OF HEADQUARTERS OFFICE—Mr. Krueger outlined the activity of the MAG Headquarters Office since the February Executive Committee meeting. He pointed out the number of meetings that have been held in that period, and outlined in general work in progress and work that is planned to be done.

REPORT OF JOURNAL—Dr. Woody presented a short report describing changes in personnel in the *Journal* office and reported that advertising revenue will probably increase for 1959.

REPORT OF CONSTITUTION AND BY-LAWS COMMITTEE—Thomas W. Goodwin, Chairman of the Constitution & By-Laws Committee and J. W. Chambers, Council Committee on Reorganization presented background information concerning the intent and development of the MAG Constitution and By-Laws in recent years. They reported on a joint meeting held Saturday morning of the MAG Constitution and By-Laws Committee and the Council Committee on Committee Reorganization. Dr. Goodwin stated the committee considered clarification of the duties of Secretary and Executive Secretary. After these preliminary remarks, Dr. Goodwin presented the report below for approval of Council before forwarding to the House of Delegates:

Recommended Amendment to the Constitution and By-Laws of MAG by Committee on Constitution and By-Laws

Recommended Changes in the Constitution

1. Change the name of the Executive Secretary or Assistant Executive Secretary wherever either appears to read Executive Director and Assistant Executive Director respectively.

Recommended Changes in the By-Laws

1. Amend second sentence of Chapter IV, Section 3, to read as follows:

The Executive Committee shall be composed of the President, who shall serve as Chairman of the Executive Committee, the President-Elect, the Immediate Past-President, the Secretary, the Chairman of Council, who shall serve as Vice-Chairman of the Committee, and the Chairman of the Council Committee on Finance.

2. Amend Chapter IV, Section 3, by adding the following sentence at end of section:

Between meetings of the Executive Committee, the Chairman of the Executive Committee shall direct the Executive Secretary as to undetermined matters of policy.

3. Amend Chapter IV, Section 2, by changing the last two sentences to read as follows:

The Council may designate the Secretary or the Executive Secretary or Assistant Secretary to serve as Secretary of Council.

4. Amend Chapter V, Section 1 by adding the following sentence immediately before the last sentence of the section:

No member shall hold the office of Secretary or Speaker more than two consecutive terms.

5. Amend third and fourth sentences of Chapter VI, Section 4 (A) to read as follows:

The Executive Committee may designate the Secretary or the Executive Secretary or Assistant Executive Secretary to serve as Secretary of the Executive Committee.

6. Amend first paragraph of Chapter VI, Section 4 (B) to read as follows:

The Secretary or Executive Secretary, under the direction of the Executive Committee of Council, shall be custodian of all Association record books and papers, maintain membership records, issue membership cards and provide for the registration of members at annual sessions.

7. Amend second sentence, Chapter VIII, Section 1 to read as follows:

The Treasurer shall be a member in good standing for at least three years prior to his appointment, and may not be the same member who holds the office of Secretary.

On motion (Simpson-Alexander) it was voted to approve this report of the Constitution and By-Laws Committee as read for forwarding to the House of Delegates.

PODIATRY ASSOCIATION REQUEST—Podiatrists Wm. J. Meadors of Columbus and Dalton McGlamary of Atlanta presented a discussion of the scope and aims of podiatrists in Georgia. Dr. Meadors in making the presentation pointed out the desires of podiatrists to work with the medical profession and specifically requested scientific booth spaces for an exhibit at the MAG Annual Session explaining the training of podiatrists and the type of practice they conduct. General discussion ensued.

After the presentation by Dr. Meadors and Dr. McGlamary, it was voted (Goodwin-Alexander) to permit the Georgia Podiatry Association to exhibit at the annual session as requested.

LEGISLATIVE COMMITTEE REPORT—A report of the Legislative Committee was presented by Mr. John Kiser in behalf of the Legislative Committee Chairman J. Frank Walker and Vice-Chairman Eustace Allen. Mr. Kiser summarized the activity of the 1959 session of the Georgia General Assembly. Certain bills were discussed and their final status commented on. President-Elect Wolff discussed the future legislative picture. Dr. Wood suggested that a comparison of the educational requisites of doctors of medicine and other branches of the healing arts be published in the *Journal of the Medical Association of Georgia* for ready reference by physicians.

On motion (Wolff-Peterson) the matter of future legislative activity was referred back to the Legislative Committee for consideration and report at the July Council meeting.

On motion (Simpson-Alexander) it was voted to commend the Headquarters Office for staff activity in behalf of the Legislative Committee during the 1959 General Assembly.

The Keogh-Simpson Bill was brought to the attention of Council and Councilors were asked to communicate with members of the House of Representatives on this matter.

MILLEDGEVILLE STUDY COMMITTEE—Vice Chairman of Council J. G. McDaniel discussed the present publicity and interest in the professional and operational policies of the Milledgeville State Hospital. Dr. McDaniel gave background data on the matter. President Lee Howard, Sr. then related that the Governor of the State of Georgia had called upon the Medical Association of Georgia to appoint a committee to study the matter and report back to the Governor. Dr. Howard then made the following appointments to the Milledgeville Study Committee: W. Bruce Schaefer, Toccoa, Chairman; R. Hugh Wood, Atlanta; Corbett Thigpen, Augusta; Rives Chalmers, Atlanta; and John Bell, Dublin.

By general agreement the meeting of the Council was then recessed at 5:50 P.M.

The Council of the Medical Association of Georgia was reconvened at 8:00 A.M., Sunday, March 8, 1959 and called to order by Chairman Dillinger.

FREE CHOICE OF PHYSICIAN AND CLOSED PANEL SYSTEM—David R. Thomas, Chairman of the Association Insurance Committee read a request from AMA House of Delegates seeking MAG policy on free choice of physician and policy on closed panel systems which restrict free choice of physician. This information was requested from all State Medical Associations for referral to the AMA House of Delegates.

Dr. Thomas then read the communication as follows:

"The House of Delegates also voted to adopt the further recommendation of the Reference Committee that the constituent Associations be urged to review the report and transmit their decisions with regard to the following basic points:

"(1) Free choice of physician—acknowledging the importance of free choice of physician, is this concept to be considered as a fundamental principal, incontrovertible, unalterable, and essential to good medical care without qualification?

"(2) Closed panel systems—what is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician."

At this time Chairman Dillinger called for general discussion and asked the Councilors for their individual opinions. A motion made by Dr. Thomas was withdrawn when the following substitute motion was approved:

On substitute motion (McDaniel-Simpson) it was voted that the Medical Association of Georgia is for free choice of physician and that this concept be considered a fundamental principle.

Drs. Wolff and Howard then made a motion which was withdrawn when the following substitute motion was approved as follows:

On substitute motion (Tift-Alexander) it was voted that Council of the Medical Association of Georgia notify the American Medical Association that it is a policy of the MAG to oppose any system of medical care which restricts free choice of physician, but if any member of the Medical Association of Georgia does participate in a restricted system, any disciplinary action should be at the discretion of the local medical society.

1959 COUNTY SOCIETY OFFICERS CONFERENCE REPORT—A report on the 1959 Conference for County Society Officers held at the Atlanta Biltmore Hotel, February 15, 1959 was presented by John Heard, Chairman of the Association Public Service Committee. This report was received for information. By general agreement a rising vote of commendation was given Dr. Heard on the excellence of the program.

HEALTH CARE OF AGING—David R. Thomas and Charles S. Jones, Co-Chairman of the Association Insurance and Economics Committee discussed an overall program for all aspects of "Health Care of the Aging" in Georgia. General discussion of this problem ensued and it was noted that seven Association committees were already concerned with this problem. Various plans of action to coordinate the Association Committees were discussed. On motion (Simpson-McDaniel) it was voted that the Insurance and Economics Committee under the direction of the Executive Committee of Council proceed to study and devise a program for the "Health Care of the Aging" in Georgia.

On motion (McDaniel-Alexander) it was voted that such funds for the initiation of a program of "Health Care of the Aging" could be approved by the Executive Committee of Council to be charged to the contingent fund.

MAG BUILDING COMMITTEE REPORT—Chris J. McLoughlin, Chairman of the MAG Building Committee reported on the progress of obtaining a site and building in Atlanta. The report was received for information and there was some discussion about the possibility of a site for the Headquarters Office Building in Macon.

UNFINISHED BUSINESS

(1) New MAG Seal—Secretary McLoughlin took a poll of the members of Council on four proposed revisions of the present MAG seal. This poll was received for information.

(2) MAG Standardized Insurance Forms—Secretary McLoughlin reported for information on the progress on the Association's standardized insurance form for health and accident claims and this report was received for information.

(3) School Child Health Insurance—Secretary McLoughlin reported on certain data and was informed the Insurance and Economics Committee Chairman Dr. David R. Thomas and General Counsel Shackelford have this problem under advisement at the present time.

NEW BUSINESS

(1) Simmons Mattress Company Advertisement—Dr. J. G. McDaniel presented an advertisement appearing in the *Atlanta Constitution* on March 26, 1958 prepared by the Simmons Mattress Company advertising mattresses for the firm of Myers-Peachtree. The advertisement was addressed "To the Doctors of Georgia." General discussion ensued.

On motion (McDaniel-McLoughlin) it was voted to write a letter to the Simmons Company and the local distributor, Myers-Peachtree, condemning such advertising practices.

(2) Optometry Problem—Dr. Henry Tift presented a complaint from the Bibb County Medical Society concerning the unethical and possible illegal practice by an optometrist in the area. On motion (Eldridge-Tift) it was voted to approve that the Bibb County Medical Society forward their complaint on this matter to the Georgia Optometry Association.

(3) MAG Annual Session Awards—By general agreement it

was approved that Association Certificates of Appreciation should be awarded as follows: Lee Howard, Sr., President of MAG; Mrs. Luther Wolff, President, Auxiliary to MAG; David R. Thomas—Chairman Insurance and Economics Committee; Charles S. Jones, Former Medicare Chairman; George Dillinger—Chairman of Council; Edgar Pund—Service of Medical Teaching; and Mr. John Dunaway—Former Association General Counsel.

(4) Athletic Injury Treatment—A communication was read from the Chairman of the Association Committee on Crippled Children, Dr. Jack Hughston. His letter requested authority to send to the secretaries of the county medical societies a letter urging each county medical society to have a physician on high school football team bench as an athletic injury physician. On motion (Goodwin-Alexander) it was voted to approve him sending a letter to the secretaries of the county medical societies over his signature as Chairman of the Crippled Children's Committee, provided that a draft of such letter be approved by the Association Secretary prior to its mailing.

(5) Social Security Coverage for Physicians—Charles Jones, Co-Chairman of the Insurance and Economics Committee discussed the inclusion of physicians under the present Social Security system. General discussion ensued. On motion (Goodwin-Alexander) it was voted that Council recommend to the House of Delegates that physicians in Georgia be included under OASI (Social Security) and that the Association AMA Delegates be so advised.

(6) Medical Education Committee Report—Secretary McLoughlin presented a report from Charles Stone, Chairman of the Association Medical Education Committee, which was accepted for information.

(7) Approval of Annual Session Program—On motion (McDaniel-Williams) it was voted that the Council approves the 1959 Scientific Program of the Association's Annual Session, May 17-20, Bon Air Hotel, Augusta, Georgia as presented by Annual Session Chairman Henry Tift.

(8) Glynn County Medical Society Charter—Mr. Krueger read a communication from Glynn County Medical Society in which they requested a charter, herewith submitting their Constitution and By-Laws. It was believed that this Society already had a charter and the matter was referred to Vice-Councilor James Hicks for clarification with the authority to re-charter the Glynn County Medical Society, if their charter was lost.

(9) Membership Clarification—Councilor Addison Simpson discussed clarification of membership under Chapter I, Membership, Section 10, Jurisdiction, as passed by the House of Delegates as an addition to the Constitution and By-Laws of the Association April 30, 1958. It was made quite clear that this section was not retroactive and on motion (Simpson-Williams) it was voted to request the Executive Secretary to write the Oconee Valley Medical Society that: "In its December meeting the Council of the Medical Association of Georgia ruled that the additional section of Chapter I, Section 10 titled Jurisdiction, under the revision of the Constitution and By-Laws as revised by the House of Delegates, April 30, 1958 was not retroactive." The motion further requested that a copy of this action be sent to the Councilor of the 10th District. This motion was approved.

(10) Milledgeville Study Committee—By general agreement it was approved that MAG General Counsel should advise the committee meetings of the Milledgeville Study Committee as suggested, and funds are hereby approved from the contingent fund for this activity.

(11) Headquarters Office Equipment—President Lee Howard, Sr., discussed the present need for a conference table and chairs in the Headquarters Office. Secretary McLoughlin stated that any equipment purchased should be purchased with the view in mind as to proposed new headquarters office building. On motion (Howard-McLoughlin) it was voted that a table, chairs, and desks be replaced as needed from contingent funds if equipment funds are not sufficient, at the discretion of the Executive Committee of Council.

(12) On the Death of Dr. George P. Kinnard—By general agreement the Association Secretary was instructed to write a letter to the family of Dr. George Kinnard, Newnan, MAG

Vice-Councilor expressing the appreciation of Council for Dr. Kinnard's service in behalf of the profession in Georgia.

(13) Site and Date of Next Council Meeting—At the invitation of Drs. Goodwin, Thomas, and Hock of Augusta, the Council of the Medical Association of Georgia will meet at 2 P.M., Saturday, May 16 at the Bon Air Hotel, Augusta, Georgia.

(14) Discussion ensued about the July Council meeting at Callaway Gardens at the invitation of Dr. J. W. Chambers and on motion (McDaniel-Williams) it was voted to recommend that the Council accept the gracious invitation of Dr. J. W. Chambers to meet in July, 1959 at the Callaway Gardens and this action was referred to the organizational meeting of the Council immediately after the 1959 May Annual Session.

The Chairman called for further business and there being none the meeting was adjourned at 12 Noon.

WEEKLY HEALTH COLUMN COMMITTEE MEETING

THE MEETING OF MAG Weekly Health Column Committee was called to order Wednesday, March 11, 1959 at MAG Headquarters Office, Academy of Medicine, Atlanta at 7:20 P.M. by Chairman H. C. Derrick, Jr., LaFayette.

Present, in addition to Chairman Derrick were: August C. Yochem, Jr., Atlanta; E. P. Inglis, Marietta; Jule C. Neal, Macon; T. J. Vansant, Marietta; Mrs. Bob Christian, Atlanta; and Mr. John Kiser and Mrs. Emily Grinalds of the Headquarters Office Staff.

The Committee voted to approve the release for publication the article on smoking, with certain additions.

The following articles were read and approved for release:

- 1. Sebaceous Cysts Are Common Skin Disorders
- 2. First Anesthetic Administered in Georgia
- 3. Fever Blisters More Nuisance Than Danger
- 4. Cancer of the Uterus Is Easily Diagnosed
- 5. Mental Illness Shouldn't Be Hidden

Articles to be approved at next meeting are:

- Childbirth (Neal)
- Worms (Inglis)
- Obesity (Inglis)
- Nephritis (Derrick)
- Joys of Eating (Neal)

Articles for discussion at the next meeting are as follows:

- What to Expect Following Hysterectomy Neal
- Menopause Can Be a Pleasure Neal
- Tuberculosis Inglis
- Ear Infections Inglis
- Heart Attacks Vansant
- Athletes Foot Vansant
- Pink Eye Vansant
- Sprained Ankles Vansant
- Warts Derrick
- Epilepsy Derrick
- Emotional Versus Mental Illnesses Yochem
- Pilodinal Cysts Glass
- Any Subject Glass

Mr. Kiser was instructed to purchase Merck's Manual for the use of Mrs. Bob Christian. Mrs. Grinalds was instructed to send a list to all Committee members of all articles published in the Weekly Health Column showing the number of times each article has been published in various papers at various times. Chairman requested that Mrs. Christian be paid to date.

It was duly voted and seconded that the next meeting of MAG Weekly Health Column Committee be held on April 8, 1959 at 7 P.M., Headquarters Office, Academy of Medicine, Atlanta, Georgia.

There being no further business, the meeting was adjourned at 9:00 P.M.

ATTEND 1959 ANNUAL SESSION

BLUE CROSS-BLUE SHIELD ADDRESS BY DR. ORR

AMERICAN MEDICINE'S PARTNERSHIP with Blue Shield in extending the benefits of prepaid medical care was the theme of the Annual Blue Shield National Professional Relations Conference held in Chicago recently.

The conference brought together a record total of more than 300 people, half of whom were physician trustees representing Blue Shield Plan governing boards and officers of 20 state medical societies. The executive secretaries of some 25 state and county societies and 130 Blue Shield Professional Relations personnel comprised the balance of the conference group.

In a keynote address, Dr. Louis M. Orr, of Orlando, Florida, President-Elect of the American Medical Association, commended Blue Shield for its "magnificent role" in developing the medical prepayment program, and urged "all members of the health team" to "recapture the pioneering spirit which was the foundation on which Blue Cross and Blue Shield were built."

"Let's stand together and stand united against

the thrusts of big government into the medical care field," Dr. Orr urged. "And equally important, let's step up the current vigorous program to provide realistic positive approaches to all phases of health care among all people, young or old."

Referring directly to the needs of "senior citizens," Dr. Orr said he was "gratified that Blue Shield has been one of the first to pledge its all-out cooperation in working with the medical profession to do an effective job in providing medical care for the aged, especially the lower income group." He also commended Blue Shield's present accomplishments in developing a model contract for people over 65, and progress in removing age limits on non-group enrollment.

Calling for an ever greater effort in this area, Dr. Orr said that "the future of medicine and voluntary enterprise may well be determined largely by the extent to which Blue Shield and other voluntary financing mechanisms expand their coverage of the older citizens."

SCIENTIFIC SESSION OF AMERICAN HEART ASSOCIATION

THE 1959 ANNUAL MEETING and Scientific Sessions of the American Heart Association will be held October 23-27 in Philadelphia. The Scientific Sessions are scheduled for October 23-25 at the Trade and Convention Center. The Annual Meeting of the National Assembly, delegate body representing all program interests and geographical areas of the Association, will be held in the Hotel Bellevue Stratford, October 26-27.

A deadline of June 12 has been set for submission of abstracts of papers to be presented at the Scientific Sessions and for space applications for scientific exhibits. Papers intended for presentation must

be based on original investigation in, or related to, the cardiovascular field. Official forms for submitting abstracts and space applications for scientific exhibits may be obtained from Dr. F. J. Lewy, Assistant Medical Director, American Heart Association. Applications for space for industrial exhibits may be requested through Steven K. Herlitz, Inc., 280 Madison Avenue, New York 16, N. Y.

Inquiries concerning hotel reservations and the Assembly meetings may be addressed to William F. McGlone, Secretary, American Heart Association, 44 East 23rd Street, New York 10, N. Y.

THE NATIONAL FOUNDATION ADVISORY COMMITTEE

THE NATIONAL FOUNDATION has enlarged its Advisory Committee on Professional Education from 10 to 16 members, Basil O'Connor, president of the organization announced this month. Chairman of the new committee is Dr. Thomas B. Turner, dean of the medical faculty, The Johns Hopkins University, Baltimore. Dr. Turner is also vice-chairman of the organization's committee on research.

The committee, composed of some of the nation's

foremost authorities in health and education, is credited by Mr. O'Connor as being responsible for a large part of the unique success of The National Foundation's professional education program in the past. This year, for the first time, The National Foundation will support a health scholarship program for the basic preparation of a younger age group in medicine, nursing, physical therapy, occupational therapy, and medical social work.

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WHAT CAN BE DONE ABOUT THE STAPHYLOCOCCAL DISEASE PROBLEM

A practical approach to this complicated situation is outlined.

John T. Godwin, M.D.* and Andre J. Nahmias, M.D., M.P.H.,** *Atlanta*

IN A GUEST EDITORIAL in the October 1958 issue of the *Journal of the Medical Association of Georgia*, Dr. F. Dunn, Chief, Staphylococcal Disease Unit at the Communicable Disease Center, discussed the staphylococcal disease problem in general terms. We would like to follow this article with a more detailed discussion of what can be done about this problem, with particular reference to the collaborative study which was conducted between St. Joseph's Infirmary in Atlanta and the Communicable Disease Center of the U. S. Public Health Service. The formation of the Infections Committee of the Fulton County Medical Society and what it hopes to accomplish on a community level will also be discussed.

In many hospitals in the United States, staphylococcal infections have attained an endemic level and the small number of cases that are hospital-acquired do not usually cause much concern for several reasons:

1. The fact that one-third to two-thirds of

these infections occur only after the patient leaves the hospital so that association of these lesions with the hospital is usually not recognized—the *problem of follow-up*.

2. The fact that these infections may occur in patients on different services attended by different physicians, so that a connection between these sporadic cases is not readily made—the *problem of communication*.
3. The fact that we do not possess, as yet, absolute criteria for "acceptable" rates of infection—for instance, is three per cent postoperative wound infections an acceptable figure?—the *problem of basic information*.
4. The fact that it is difficult to face the problem squarely, hoping that it will disappear eventually by itself—the *problem of the ostrich in the sand*.

It is unfortunate that in so many instances an outbreak of epidemic proportions must strike before active concern is expressed and attempts at control are made.

However, assuming that an Infections Committee had been formed or is in the process of being formed in your hospital, we would like to suggest

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a general approach to the staphylococcal problem (Table 1).

TABLE 1

A General Approach to the Staphylococcal Problem

- A. Determining the problem—its existence and its extent.
- B. Performing pertinent bacteriological surveys—follow-up surveys on patients—physical examination of personnel.
- C. Observing techniques and physical conditions within the hospital and recommending changes if needed.
- D. Establishing specific control measures.
- E. Beginning an education program for the whole hospital personnel followed by a continuous in-training education program.
- F. Setting up an effective surveillance system.
- G. Doing investigative research whenever feasible and sharing experiences with other hospitals.

We will now discuss the various points as they are related to our hospital.

Determining the Problem—Its Existence and Its Extent

It was believed that the rate of surgical infections had increased in the months of August and September, 1958. In order to substantiate that impression, three sources of information were investigated to arrive at a clearer picture of the actual facts:

1. *Questionnaire to physicians on the staff:* Table 1 shows the response by 100 staff physicians to a questionnaire aimed at obtaining an idea of the trend of infections in our hospital and in other hospitals in Atlanta. The tabulated response confirmed the impression that wound infections were the most important problem at this hospital (33 out of 94 wound infections reported). However, the response gave us much more information. It pointed to the fact that other Atlanta hospitals appeared to also have staphylococcal infections—some of a severe nature (seven with septicemia and 10 with staphylococcal pneumonia). It confirmed the fact that most staphylococcal lesions seen are skin lesions. It pointed to the value of follow-up to ascertain the full extent of a hospital staphylococcal problem since, for instance, 25 of the 94 wound infections were seen in the office and several skin lesions in newborn babies were noted after they had left the hospital. The number of physicians culturing all suspected infections and using chemoprophylaxis was of significant interest.
2. *Review of bacteriological cultures:* The reliability of this source is dependent on the number of infections which are cultured. A

TABLE 2

Total Response by 100 Staff Physicians

Have noted in past year Staph infections in patients				Have noted increase over past year		
	Yes	No	Un-known	Yes	No	Un-known
In this hospital	36	64	0	23	38	39
In other hospitals						
in city	51	46	3	32	33	35
In their office	55	38	7	19	52	29
Type of Infections	Total	No. in this hospital	No. in other hospitals	No. in office		
Skin lesions	413	15	35	363		
Pneumonia	17	1	16	0		
Wound infections	94	33	36	25		
Septicemia	11	3	7	1		
Other	12	2	1	9		
	547	54	95	398		
		(about 10%)	(about 20%)	(about 70%)		
MD's culturing all suspected infections:	Yes 47	No 38	Some 15			
MD's using prophylactic antibiotics:	In none of their cases — 39	In 25% of their cases — 26	In 50% of their cases — 13	In 75% of their cases — 7	In 100% of their cases — 15	

rough estimate from Table 1 would show that only between 50 and 65 per cent of infections are cultured. Even with this being true it was noted that from January 1958, until October 1958 the incidence of other staphylococcal infections, which included cultures of patients admitted with established staphylococcal lesions and of patients with superficial skin lesions, was fairly stable. On the other hand, the incidence of postoperative infections which had been running between one and three a month had risen to six and seven a month from August 1958 to October 1958.

3. *Review of medical charts coded as staphylococcal infections:* Only about half of the patients with infections actually cultured and found to be due to the staphylococcus were coded on the medical charts as such. This points to the need for physicians to report all such infections when they do occur. However, again these records also pointed to the problem as being mainly a surgical one.

We had then at our hospital the "impression" that there was a surgical staphylococcal problem in this hospital which was confirmed by all three sources used for information. There was no evidence of the problem extending to the nursery or to medical patients.

Surveys

1. *Performing pertinent bacteriological surveys:* All cultures from lesions of patients were phage-typed by Dr. Elaine Updyke, Laboratory Branch, CDC. It was soon found that the ill-reputed "hot" strain 80/81 was the one causing our trouble. Bacteriological surveys were made of surgical

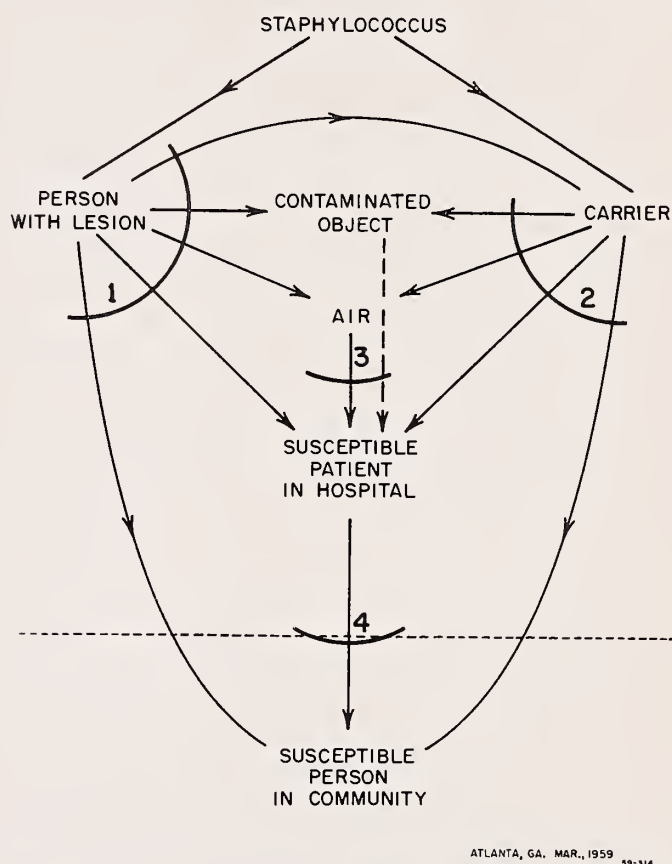


Figure 1. Routes of transmission of the staphylococcus within a hospital and out into the community.

which have been traced to the nurse with a boil or the surgeon with a furuncle. These people must be treated and informed of their possible role in spreading infection, not only to patients, but also to other personnel and to members of their family.

Control 2: Recognition and proper disposition of carriers: A carrier on the surgical team was found to be closely related to several of the postoperative infections. Adequate disposition of this individual with temporary removal from patient care and treatment caused the infections to cease. That person was cleared of his carrier state and has returned to duty with no more associated infections.

If there had been a problem in the nursery, it would have been important to determine the carrier state of the babies in that nursery as they are potential spreaders to their family, particularly their nursing mothers.

Control 3: Good aseptic technique: This will control spread through the air or contaminated objects. Attainment of good technique by every member of the hospital team is dependent on each person knowing exactly what his duty is. This is essentially a problem in education which will be discussed later.

Control 4: Proper management of the susceptible

personnel and of the air and equipment in the O.R. A bacteriological evaluation was made of such techniques as preoperative hand scrubbing and preparation of the patient's skin. This study established the need of frequent changes of mask during long operations. General bacteriological surveys of the whole hospital personnel were not made because the epidemiological evidence did not point to such a need and because the problem was well-limited. However, a survey of the interne and resident staff was made and carriers of the "hot" strain have been treated. A bacteriological survey of nursery personnel is contemplated because of the critical nature of this particular area in the hospital.

2. *Follow-up survey of patients:* A telephone survey of about 150 mothers who delivered during the three months when the surgical infections had increased was made with the help of the nurses of the State Health Department and CDC. A small incidence of pustular lesions in babies, which would not otherwise have been recognized, was disclosed by this method.

3. *Physical examination of personnel:* This method was not necessary in this study but is recommended in case of sudden outbreaks as it may point to personnel with lesions who would go undetected otherwise.

Observation of Techniques and Physical Conditions within the hospital—Recommendations

Detailed observation was made of the operating room, the nursery, and isolation techniques. Specific recommendations were made to the hospital administration, many of which have already been adopted; others are still being considered.

Establishing Specific Control Measures

Figure 1 shows the routes of transmission of the staphylococcus within a hospital and out into the community. Specific control measures must take into consideration these routes and create barriers at appropriate points. These controls are marked one to four on the figure.

Control: 1A: Complete isolation (which we prefer to call *Special Care*) of any patient who is suspected on admission or during hospitalization of having a staphylococcal lesion is perhaps the most difficult and yet most important control measure in protecting other patients, personnel, and visitors from becoming asymptomatic carriers or developing clinical disease. This is now routine at our hospital.

1B: Removal of any personnel with a lesion from patient care: The literature cites several outbreaks

STAPHYLOCOCCAL DISEASE / Godwin

patient who has become infected: Many of these patients will not develop their lesions while in the hospital. It is important that consideration of this possibility be made of every person who comes into the office with an infection since most hospital-associated staphylococcal infections are resistant to penicillin, streptomycin, the tetracyclines, and often also to erythromycin and other antibiotics. Adequate therapy would thus be helped by cognizance of this hospital association. Only culture of such patients with antibiotic sensitivity tests will lead to the most efficacious therapy, in conjunction with surgical drainage where needed. Such persons are potential sources of infection for other people in the community and good hygienic techniques should be advised. If necessary, the public health nurse can be of help in this area.

Education Program

An education program for personnel was conducted which reached all, from the lowest member on the hospital team to the highest. This was done with the help of the Training Branch of CDC using many of their audiovisual training aids. It is important that a continuing in-service training program be carried on, particularly for new personnel since relaxation of control measures on the part of any person would tend to continue the vicious cycle.

Surveillance System

To be continually on top of the problem, the following system has been adopted:

Any suspected infections are reported on a special form from the ward to the Infections Committee. A Chief of Service on that committee rotates for two months as Infections Coordinator. He meets bi-weekly with two residents who rotate every two months as "infections" residents. These residents follow up the reports from the wards, ascertain the results of bacteriological cultures recommending cultures be taken if not already done and recommending isolation (special care) be started after consultation with the Infections Coordinator and the patient's physician. As a double-

check measure these "infections residents" go on rounds every day to ascertain from each nursing station the presence of any infection not reported or not cultured.

By this method then, the following is accomplished:

- 1. Suspected infections are confirmed bacteriologically and clinically and placed in isolation to protect personnel, visitors, and other patients.
- 2. A true incidence of infections that *occur in the hospital* is obtained. Whenever needed, epidemiological and laboratory investigations are done to define the mode of acquisition of a particular infection. Physicians who see infections *outside* the hospital report them to the Infections Committee.
- 3. This system allows for the house staff to become acquainted with the bacteriological and clinical manifestations of infections as well as their therapy. By the end of the two months of rotation it is hoped they will have become competent hospital epidemiologists.

Research and Exchange of Information

While working on this program, several interesting points for investigation have come up in the bacteriological and epidemiological aspects of this disease. Since our knowledge is still so imperfect regarding this problem, it is hoped that wherever possible such investigations will be carried out.

In order to provide a meeting ground for the experiences of various hospitals to be shared so as to present a united front against this disease in our community, the Fulton County Medical Society has appointed a Committee on Infections. This committee has met twice so far and the need for its existence is quite apparent. Its functions have been defined as: education, research, laboratory services, surveillance, and standards. With this concerted attack by the medical, nursing, administrative, and public health groups of the whole community, we feel confident we can do a great deal in controlling and helping to eradicate the staphylococcal disease problem.

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TREATMENT OF SHOCK IN DIABETIC ACIDOSIS

Dextran serves as an important addition to therapy in the diabetic in acidosis.

Walter Lyon Bloom, M.D., *Atlanta*

FAILURE OF THE ABILITY to utilize glucose in diabetes produces a sequence of events which result in profound alterations in metabolism as well as the electrolyte and fluid balance. Standard textbooks^{1,2,3,4}, lucidly describe the therapy which must be instituted to correct the disturbances in metabolism, electrolytes, and fluid. The alteration of circulatory insufficiency in the patient in diabetic acidosis has received less emphasis. This paper will not deal with the problems of correction of the disturbances in metabolism or electrolytes but will stress the importance of treatment of the circulatory insufficiency which is commonly found in the patient in diabetic acidosis. The depletion of electrolyte and extracellular fluid which progresses in diabetic acidosis eventually encroaches upon the plasma volume resulting in a circulating volume inadequate to fill the vascular volume. The result is shock.

The study to be presented indicates that hypotension is a frequent occurrence in the patient admitted in diabetic acidosis and coma, that fluid replacement alone often will not establish normal circulatory dynamics as rapidly as is possible with a plasma volume expander. Dextran provides an ideal replacement therapy for the purpose of expansion of plasma volume in the diabetic patient as there has been little loss of red cells or protein from the circulation.

Method

Six patients with a diagnosis of diabetic acidosis and coma and evidence of circulatory inadequacy have been treated with intravenous six per cent Dextran in Normal Saline® during the early phase of their fluid replacement. The summary of the laboratory and clinical response of these patients is presented in Table I. All of the patients had initial carbon dioxide combining power below 15 volumes per cent, marked hyperglycemia, and in most instances, some degree of nitrogen retention. It may

also be seen that all of these patients had some degree of shock at the time that they were treated as was evident from the decreased blood pressure, tachycardia, and in two instances oliguria. The treatment of the metabolic and electrolyte disturbances conformed to the accepted pattern of insulin replacement, electrolyte replacement, fluid replacement, and the administration of carbohydrate. All of the patients received potassium during therapy.

The plasma volume of one patient, L. H., was determined at the time of admission, three days after her recovery from diabetic acidosis, and again two months later when she was under normal control for her diabetes. Since patients with diabetic acidosis have considerable lipemia, the measurement of plasma volume by dye procedures is inadequate and in this instance the use of iodine tagged albumin⁵ as well as a recently described method of the use of large molecular weight dextran was performed.⁶

Results

It may be seen that circulatory inadequacy as evidenced by hypotension was a frequent finding in the patients in diabetic acidosis. In several of the instances (M.H. & Q.W.) fluid replacement with physiological saline was undertaken and the patient's blood pressure did not respond. Following this, dextran was administered and the blood pressure promptly returned to normal. In two instances blood was also administered because of anemia (B.M.) and blood loss (M.H.). In these two patients, the dextran was used to support the circulating volume until blood could be administered. Clinical evidence of response was demonstrated by increase in blood pressure in all patients and in two patients by a re-institution of normal urine output which was suppressed at the time that the patient was admitted to the hospital. It may be seen that the blood urea nitrogen indicated nitrogen retention resulting from failure of the circulation to

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DIABETIC ACIDOSIS / Bloom

provide adequate renal blood flow. In all but one patient the blood urea nitrogen returned to normal during therapy. In the patient in which blood urea nitrogen did not return to normal, the patient succumbed from a nectotizing membranous colitis and in this patient there was a progressive rise in the blood urea nitrogen. Patients in whom the hematocrit was measured showed hemoconcentration on admission which responded promptly to plasma volume expansion. It is interesting that although urine output increased and blood pressure returned to normotensive levels in all the patients, tachycardia persisted until changes in the metabolism became evident.

The one study of plasma volume in a patient in diabetic acidosis showed reduction of volume to al-

most one half of normal. (L.H., Table I) If the plasma volume measured two months after admission, when the patient's diabetes was controlled, can be assumed to be an estimate of her normal volume, the patient's plasma volume in acidosis was diminished by 1200cc. Therefore, the 1000cc. of dextran injected should have restored the circulating volume to normal. The blood pressure changes provide clinical evidence of return of the plasma volume toward normal. As previously mentioned, the rapid pulse rate of this diabetic patient did not return to normal until the metabolic changes showed evidence of reverting toward normal.

Discussion

The six clinical records of patients in diabetic acidosis indicate that hypotension and ntirogen retention are of frequent occurrence in the patient in diabetic acidosis and coma. This is the result of a sequence of metabolic events which might be over simplified in the following manner. Inability to utilize glucose results in mobilization of energy sources of protein and fat from the depot reserves. The glucose which is produced from protein breakdown cannot be utilized and glucosuria progresses with resultant water loss. Fat is mobilized at a rate which exceeds energy needs and the ketone bodies which are produced from fat catabolism in the liver accumulate in the blood. Since the ketone bodies are acid, the kidney must excrete the acid at a rate which often exceeds ammonia synthesis by the kidney. As a result, sodium is the base excreted and the loss may exceed the intake. The net result is the complicated clinical problem which confronts the physician when he is called upon to treat a patient in diabetic acidosis and coma.

From the foregoing over simplified discussion it can be seen that there are losses of sodium and water which deplete the extra cellular fluid. When dehydration proceeds far enough, plasma, water, and electrolyte are lost and plasma volume decreases. With a decrease in plasma volume the first changes will be a constriction of the blood vessels to try and fit the circulating volume to the size of the vascular volume. However, as the water and electrolyte depletion exceed the capacity of the blood vessels to be constricted, the blood pressure will drop as there is insufficient circulating fluid to fill the blood vessels. It may be seen that this is a severe threat to the patient's existence as the increased metabolic demands of the diabetic state are confronted with an inadequate circulation and peripheral circulatory collapse in the diabetic patient in acidosis is a major obstacle to the further treatment.^{7,8}

A first objective of treatment of diabetic acidosis is to reverse the metabolic events in the cell (in-

TABLE I
Clinical Findings of Patients in Diabetic Acidosis Treated for Shock

Time	R	P	BP	CO ₂	BUN	Blood Sugar	HT	Plasma Volume
Pt. L. N.								
Adm. 2:45	38	148	70/0	3.5		566.	44	1841cc
(Remark: 1000cc dextran)								
1 hr.	48	140	130/50					
4 hr.	28	100	120/50	10		400	33	
(Remark: Recovery)								
2nd day	20	80	120/60	25		150	33	3350cc
2nd mo.	20	80	120/60					3073cc
Pt. E. M.								
Adm. 11:30	30	130	70/45	10	34	560		
(Remark: 1000cc dextran)								
1 hr.		125	120/70					
2 hr.	24	125	130/80					
6 hr.	20	110	140/80	19	17	300		
(Remark: Recovery)								
Pt. M. H.								
Adm. 10:00	44	156	104/74	9	33	528	35	
(Remark: 3000cc Fluid and Levophed)								
5 hr.		150	80/60					
(Remark: Dextran and 1000cc whole blood)								
7 hr.		100	130/60				42	
(Remark: BP remained stable until 24 hours later, Patient died—Membranous enterocolitis)								
Pt. Q. W.								
Adm. 1:00	30	104	105/40	7		612		
1½ hr.	30	100	105/40					
0/0 (Remark: No clinical response 2000cc fluid saline 500cc dextran)								
1¾ hr.	24		120/50					
4 hr.	20	90	120/60	16		490		
(Remark: Recovery)								
Pt. M. D.								
Adm. 3:00	36	120	110/60	14	42	500	52	
(Remark: 500cc dextran)								
1 hr.	36	120	125/80					
4½ hr.		110	140/80	20	7	288	34	
(Remark: Recovery)								
Pt. B. M.								
Adm. 7:30	32	120	0/0	4.2	48	485	Hb. 12.	
(Remark: 500cc dextran, 500cc Blood)								
1 hr.	32	120	80/40					
2 hr.	32	120	110/60				11.5	
(Remark: Recovery)								
1 day	20	80	140/80	22	15	120	12.0	

sulin) and to provide the cell with a normal environment (fluid and electrolyte). The urgent need of having a normal circulation to accomplish these aims is apparent.

It is not as easy to prove this point in the diabetic in acidosis as it is to explain the problem. Since treatment of acidosis is comprised of a number of simultaneous important procedures, evaluation of any procedure (with the exception of insulin, sodium chloride, fluid administration) is impossible. It has been shown that plasma volume was diminished in one patient studied and that hemoconcentration was present in the other patients who had this determination. It is clear that shock or circulatory impairment is frequent in the patient in diabetic acidosis and that shock in any patient, diabetic or non diabetic, is a threat to existence which necessitates prompt treatment.

Dextran has proved a valuable clinical means of providing fluid which will remain in the circulation, consequently, increasing cardiac output and re-establishing blood flow to the tissues. The response to the treatment of shock with dextran in these six patients has been gratifying. Dextran has been shown to be more rapidly effective in re-establishing normal circulation in the diabetic in acidosis than has fluid replacement alone. Dextran has a number of advantages in the treatment of dehydration shock as the patients have not lost red cells and are hemoconcentrated at the time of treatment. Thus, unless the patient was anemic before the onset of acidosis, blood is not necessary. The risk of virus hepatitis reduces the usefulness of plasma infusion. Dextran serves as an important addition to therapy in the diabetic in acidosis as it provides rapid re-institution of normal circulation necessary to bring about the desired correction of

the defects in metabolism, fluid, and electrolyte balance.

Summary

Evidence of circulatory insufficiency has been demonstrated in six patients in diabetic acidosis. Plasma volume was diminished in all patients as evidenced by hemoconcentration and hypotension. Oliguria was present in two of the six patients. Plasma volume measurement in one patient with mild hypotension showed a reduction to two-thirds of the normal plasma volume. In two patients, administration of fluid and electrolyte did not correct the hypotension which responded to dextran administration. All six patients in shock responded satisfactorily to the administration of dextran and it was observed that early treatment of circulatory insufficiency in the diabetic in acidosis is an important procedure in the management of this medical emergency.

1968 Peachtree Road, N.W.

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Intern Program Progressive Step

ANNOUNCEMENT THAT AN intern training program will begin at Floyd Hospital this year is welcome news of a progressive event.

Arrival of four young doctors to begin a one-year period of training marks the beginning of the first internship program since the hospital was established in 1942. The doctors, recent graduates of medical schools, will spend a year as hospital staff members, gaining valuable experience in the multitude of cases which the hospital handles. As one group completes its internship each year, another will succeed it.

These physicians will be valuable additions to the hospital staff, especially in the handling of emergency cases. Their coming will insure the presence of a doctor on duty at the hospital at all times where now staff members have to share this burden on an "on call"

arrangement, in addition to their private practices.

Approval of the hospital for an intern training program reflects credit upon the present staff and administration. This approval was gained only after a thorough inspection of the hospital program by the American Medical Association's Council on Medical Education.

In the words of Hospital Administrator Robert Murphy:

"It is the beginning of a program of education that will eventually expand medical services to the people of Northwest Georgia and, more specifically, another step toward Rome's growth as a medical center."

Rome News-Tribune

A POLLEN SURVEY

A pollen mixture is suggested for the empirical treatment of certain patients with pollinosis.

IN MAY, 1954, a pollen survey was instituted to help determine the type, quantity, and periodicity of pollen present in the air of Athens, Clarke County, Georgia. This endeavor was undertaken to aid in the understanding and treatment of the "so called" hay fever patients in one of the author's practice. While pollen surveys have been (and are being) done in the Atlanta area and also for the Savannah-Brunswick areas, it was felt that more specific information for the area in question would be a valuable aid in regulating hyposensitization schedules both for known pollen allergies and for unknown but suspected pollen allergies. In addition, it was felt that if the pollens, found in sufficient quantities to be clinically important, were not too multitudinous it might be possible to work out a stock solution of pollens which could prove valuable to the practitioners of medicine in this area who treat pollen allergy by hyposensitization.

Accordingly, a pollen collector, constructed as specified by the National Pollen Survey Committee

of the American Academy of Allergy, was obtained. This was placed on a second story, completely open, uncovered sun deck. Vaseline covered glass microscope slides were exposed for a 24-hour period daily from May, 1954 to May, 1955. The slides were examined under the microscope, the width of the slides being traversed five times, which, under low power (16 mm) with 10 x oculars, gave the equivalent of approximately 1.8 sq. cm. This was converted to pollen count per cubic yard as recommended by the above mentioned committee. The major pollens identified were cross-checked against reference pollens collected from known plants or trees as the case may be.

It may be pointed out here that a close correlation was observed between the pollen counts and patients' symptoms. Since a considerable segment of one of the author's practice is composed of patients who suffer from allergy of the eye, ear, nose, and throat region, it was possible to closely compare pollen counts and actual clinical findings. A

POLLEN COUNT PER CUBIC YARD OF

12 Month Pollen Survey	ELM	MAPLE	POPLAR	RUST	CEDAR	BIRCH	PINE	OAK	HICKORY WALNUT PECAN	MULBERRY	SYCAMORE	ASH
	JANUARY		4									
	FEBRUARY	128	24	302		6	250	106	100	16		
	MARCH	112	12	140		28	160	1,176	1,596	112	10	14
	APRIL						8	642	408	964		
	MAY						90	36	60			
	JUNE		4	8	216	10	2	58	4	6	2	
	JULY				224		2	2	2			
	AUGUST				6		16					
	SEPTEMBER				4		2					
	OCTOBER				40		8					
	NOVEMBER											
	DECEMBER											
TOTALS	240	40	454	490	44	422	2,100	2,144	1,160	10	2	14

OF NORTH GEORGIA

A. P. Keller, Sr. and A. P. Keller, Jr., M.D., *Athens*

more complete description of the clinical correlations will be mentioned in a later paper concerned with one of the rarer manifestations, namely pollinosis due to pine pollen.

Our chart will serve to point out the salient features of this particular 12-month pollen survey.

From these tables it can be seen that there are two main pollen peaks in this vicinity: namely, March-April, and September. Pine and oak are responsible for the spring peak and ragweed for the fall peak. However, it becomes equally clear that at no time from February to October is this area in any sense free of pollen.

After reviewing the pollen charts, it was felt that an "Athens Pollen Mix" of oak, pecan, plantain, grass, and ragweed might be advantageous in the treatment of pollen allergy in this area and accordingly several patients have been started on such a hyposensitization schedule. Tabulated results will have to wait another year or so but so far the results

have been very encouraging. Now, being partly engaged in the study of allergy, it is not our wish to discourage skin testing, but as we all have patients who are not financially able to have skin tests and also patients who have already had skin tests in another area of the country or for some personal reason do not wish to have skin tests, then we submit that a pollen mix for this area may prove a valuable adjunct to the treatment of such patients.

Conclusions

1. A 12-month pollen survey for the Athens, Clarke County, Georgia area is presented.
2. A pollen mixture for the empirical treatment of certain patients suffering from pollinosis is suggested.
3. For the past three years close correlation has been observed between patients' symptoms and pollen count and the empiric pollen mixture has been very helpful in the control of such symptoms.

1010 Prince Avenue

AIR BY MONTH AND POLLEN TYPE

BEECH	ALTERNARIA	SMUT	HORMODENDRUM	GINKO	PLANTAIN	HONEY LOCUST	DOCK	GRASS	FUSARIUM	HELMINTHO-SPORIUM	RAGWEED	CHENOPODIUM	WORMWOOD	MIMOSA	TOTALS
															4
2											8				942
42	2		44	48				6							3,502
2	20				30			12							2,086
14	32				246			154							632
16		18	6	8	474		2	302		2				6	1,144
	2	24			104	2	8	32		2					404
	52	18	512		40	2		10		8	48				712
	96	14	76		18		6	14			1,240	102	22		1,594
	42	32			6		10	2	4		422				566
											8				8
76	246	106	638	56	918	4	26	532	4	12	1,726	102	22	6	11,594

TREATMENT OF GASTROINTESTINAL DISORDERS WITH AN ANTICHOLINERGIC TRANQUILIZER COMBINATION

A clinical evaluation of Pro-Banthine with Dartal® is reported.

Charles W. Hock, M.D., *Augusta*

EMOTIONAL STRESS IS AN IMPORTANT contributory factor to dysfunction of the gastrointestinal tract¹ in a large number of patients. The medical management of such disorders currently includes administration of drugs that inhibit secretory and motor activity; sedatives such as phenobarbital, which reduce emotional over-stimulation; and other measures such as dietary regulations, rest, antacids, and in some instances, psychotherapy.

The new synthetic anticholinergics have been of value in reducing excess motor activity and inhibiting acid secretion. Classic sedatives have some value in reducing the emotional aspect of disturbed function, but the generalized depressant action of such drugs on the central nervous system has always been disadvantageous in ambulatory patients. One of the new tranquilizers, thiopropazate dihydrochloride*, is ideally suited for relieving emotional stress in patients because it does not depress the cortex of the central nervous system.

For this study, it seemed reasonable to combine thiopropazate dihydrochloride with an effective anticholinergic drug for a combined "psychological-physiological" approach to the management of patients with gastrointestinal tract disorders. The anticholinergic used with the tranquilizer was propantheline bromide**. The two drugs were administered in a combined tablet form***.

Dartal® is chemically described as 1-(2-acetoxyethyl)-4-[3-(2-chloro-10-phenothiazinyl)propyl]

piperazine dihydrochloride. Pharmacology studies² have shown that Dartal® is effective in relieving emotional symptoms exhibited by ulcer patients and in relieving symptoms such as anxiety, tension, and hyperactivity in other patients. There is no evidence that Dartal® alters gastric secretion or motility.

The descriptive formula of Pro-Banthine® is B-diisopropylaminoethyl xanthene-9-carboxylate methobromide. Clinicians have found that it is an effective inhibitor of gastric secretion^{3,4} and that it reduces gastrointestinal hypermotility for periods of six to eight hours⁵ in doses of 30 to 45 mg. Side effects most often encountered are dryness of the mouth, blurring of vision, and hesitancy of urination.

Tablets containing 5 mg. of Dartal® and 15 mg. of Pro-Banthine® were used for this study. The single tablet is more convenient for the patient, since he is required to take only one tablet three or four times daily as opposed to six or eight tablets if the medications are taken separately.

Materials and Methods

The present study was conducted on 120 ambulatory patients with various gastrointestinal tract disturbances which were regarded as being primarily or secondarily due to emotional stress or complicated by emotional factors. The patients were widely distributed according to age, sex, and diagnosis. However, all displayed psychoneurological symptoms such as tension, anxiety, apprehension, or restlessness in addition to their gastrointestinal symptoms.

Diagnosis, in most instances, was achieved by means of a history, a physical examination, and laboratory aids. These additional examinations in-

*Dartal, trademark, G. D. Searle & Co., Chicago, Illinois.

**Pro-Banthine, trademark, G. D. Searle & Co., Chicago, Illinois.

***Pro-Banthine with Dartal, trademark, G. D. Searle & Co., Chicago, Illinois.

cluded a roentgenologic examination of the upper and lower gastrointestinal tract, urinalysis, blood chemical studies, stool examination, Kahn test, and sigmoidoscopic examination. With the aid of these procedures, it was found that 57 patients had functional bowel distress; 47, peptic ulcer; seven, gastritis; four, duodenitis; seven, pylorospasm; two, postgastrectomy syndrome; four, postcholecystectomy syndrome; two, diarrhea; three, ulcerative colitis; and one each, diverticulitis and cholecystitis. Of the 120 patients 15 were diagnosed as having more than one disorder related to the gastrointestinal tract.

When treatment with Pro-Banthine with Dartal® was instituted, all patients had such symptoms as anxiety, tension, apprehension, insomnia, depression, gas, or epigastric fullness and pressure. A majority of the patients were given one tablet of the medication four times daily; average length of administration was 11 weeks. All of the patients were placed on a low residue, non-laxative diet or a three meal ulcer diet and in addition most of them received other drug therapy such as oral anti-diabetic drugs, mood elevators, analgesics, laxatives, vitamins, or hematinics.

Results of Therapy

Results were classified by degree of relief of symptoms, either observed during periodic examination of the patients or reported by the patients themselves during a consultation. The response was considered "good to excellent" when emotional and gastrointestinal symptoms disappeared; "fair to good" when moderate relief of symptoms was achieved; "equivocal to fair" when some relief was obtained; and "poor" when no relief was obtained. Based on these criteria, good to excellent results were obtained in 91 per cent of the symptoms (see Table I), and equivocal to fair results in an additional six per cent. Most of the patients (seven per cent) who obtained either equivocal to fair or poor results had responded very poorly to other medications in the past.

Table I summarizes the response of patients according to nature of symptoms and Table II summarizes the response by type of disorder. Although constipation is a side effect attributed to Pro-Banthine®, it will be noted in Table I that of the 35 patients who had this symptom when therapy began, 24 actually obtained good to excellent relief of this symptom on combined Pro-Banthine with Dartal® therapy. In addition, of the 18 patients who had diarrhea, 16 obtained good to excellent relief of this symptom.

During the course of therapy, 40 patients reported bothersome side effects, some of which were due to Pro-Banthine with Dartal® and some of

TABLE I
Relief of Symptoms in Patients on Pro-Banthine with Dartal® Therapy

Symptom	Response				Total
	Good to Excellent	Fair to Good	Fair to Poor	Poor (No Response)	
Anxiety	34	67	7	1	109
Tension	31	64	7	1	103
Apprehension	28	48	7	1	84
Insomnia	28	39	10	4	81
Depression	4	10	1	3	18
Epigastric burning	26	22	1	2	51
Heartburn	12	13	—	1	26
"Sour stomach"	2	1	—	—	3
Chest pain	4	6	1	1	12
"Gas"	53	47	5	2	107
Epigastric fullness and pressure	45	37	4	2	88
Abdominal soreness ..	4	2	1	—	7
Abdominal pain	3	4	1	—	8
Abdominal cramps	6	5	1	1	13
Nausea	4	3	2	1	10
Vomiting	3	2	2	1	8
Constipation	13	11	6	5	35
Diarrhea	9	7	2	—	18
	91%		9%		

which must be attributed to other drugs taken concomitantly. The most common side effect attributable to Pro-Banthine with Dartal® was dryness of the mouth, reported by 13 patients. This symptom generally cleared when the dosage was reduced and/or the medication was taken after a meal rather than before a meal or on an empty stomach. Five patients reported constipation, but whether this was actually the case is doubtful. Four patients complained of "nervousness."

Whereas Pro-Banthine® alone has caused urinary retention in a fair percentage of cases, in combination with Dartal® this symptom has almost completely disappeared. In only one patient did this symptom appear, and its presence in this instance was very transient and somewhat questionable. The

TABLE II
Response of Gastrointestinal Disease to Pro-Banthine with Dartal® Therapy in 120 Patients

Diagnosis	Response				Total
	Good to Excellent	Fair to Good	Fair to Poor	Poor (No Response)	
Functional bowel distress	25	23	5	4	57
Ulcer:					
Duodenal	15	21	1	2	39
Prepyloric	—	—	—	1	1
Gastric	—	4	—	1	5
Marginal	—	1	1	—	2
Gastritis	1	4	1	1	7
Duodenitis	1	2	—	1	4
Pylorospasm	3	3	—	1	7
Postgastrectomy syndrome	—	2	—	—	2
Postcholecystectomy syndrome	—	3	—	1	4
Diarrhea	—	2	—	—	2
Ulcerative colitis	—	3	—	—	3
Diverticulitis	—	—	—	1	1
Cholecystitis	—	—	—	1	1
	84%		16%		

patient was continued on the medication, the symptom "cleared" promptly and it did not recur.

Conclusions

Pro-Banthine with Dartal® has been used on 120 patients with a wide variety of gastrointestinal tract disorders. The largest percentage of patients had functional bowel distress and the second largest group had peptic ulcers. It can safely be said that the largest group of patients seen by any gastroenterologist falls into the functional group, and those patients who have primarily an organic disease almost always have functional components. Only a minority of gastrointestinal patients suffer from "pure" gastrointestinal conditions.

The patient who has functional gastrointestinal disease tends to be a rigid person who wants everything just so; in other words, to be a perfectionist. As a result of his desire to obtain perfection when it cannot be obtained, the person's "nervousness" is reflected on his gastrointestinal tract. The value of treating the "functional" patient with a product such as Pro-Banthine with Dartal® lies in the fact that the tranquilizer component calms the individual and controls his anxieties, fears, and frustrations. The patient is alert during the day but does not experience insomnia at night with this medication. The anticholinergic component relaxes the patient's gastrointestinal musculature so that spasm is relieved and reduces gastric acidity so that lesions heal more quickly. This twofold approach is ex-

tremely important in the majority of individuals in the functional category.

In this study, Pro-Banthine with Dartal® gave excellent results in that 94 per cent of the patients with functional bowel distress obtained fair to excellent relief of symptoms and 95 per cent of those having duodenal ulcer achieved fair to excellent relief. Between 96 and 99 per cent of those having such symptoms as anxiety, tension, apprehension, epigastric burning, gas, or epigastric fullness and pressure, obtained fair to excellent relief from these symptoms.

Summary

Pro-Banthine with Dartal® is a very satisfactory medication for relieving symptoms of functional gastrointestinal disease. Most of the side effects encountered when Pro-Banthine® or other anticholinergics are administered alone are eliminated in the combined medication.

1467 Harper Street

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Merchants of Menace

DID YOU EVER HEAR of "merchants of menace?"

A pamphlet recently issued by the American Medical Association tells who they are. They're the lineal descendents of "the frontier medicine man whose potent snake oil and wolf milk elixirs were always 'smuggled out of the sacred tombs of ancient Egypt'." Nowadays, the pamphlet goes on, "the top hat and torchlights are gone—but the medicine man is still with us, and now he's beating the drums for his potions and remedies at your doorstep, on lecture platforms, and through the mail. He's the sophisticated salesman who bleats warnings against 'that tired feeling,' 'subclinical deficiencies,' 'devitalized food,' and 'aging before your time!'"

This modern medicine man offers—at handsome prices—pills, capsules, powders and other preparations

which, he swears, will compensate for deficiencies in your diet that are causing your ills. Usually his products are harmless in themselves, but they won't cure anything. So tragedy may befall an ill person who is duped into believing in the efficacy of the concoctions—and doesn't call a qualified physician until it's too late.

The AMA pamphlet points out that a well-balanced daily diet should include milk and dairy products, vegetables and fruits, meat, fowl, fish or eggs, and cereals. If we use these standard foods in reasonable balance and quantity, there's no need for supplements unless, of course, your doctor recommends them and tells you what kind to get. Don't patronize the "medicine men."

Rome News-Tribune

J. M. A. GEORGIA

INGUINAL HERNIA IN INFANTS

The risk of delay in operative intervention far outweighs any advantages obtained by waiting until the child attains larger size.

James E. Anthony, Jr., M.D., *Decatur*

IN RECENT YEARS THERE has been a reversal of opinion on the surgical treatment of inguinal hernias in infancy. Prior to about 1940, most surgeons preferred to wait until the child was well beyond his second year of life before attempting repair of the hernia. In fact, in "Holt's Diseases of Infancy and Childhood," 11th edition, there are these two statements, in reference to inguinal hernia. "Incarceration is uncommon and strangulation even more so." . . . "Perhaps the majority of cases persisting after the end of the second year will eventually come to operation."¹ Both of these viewpoints represented the general thinking of that era, but today are not tenable. Gradually it became obvious that waiting proved to be a more serious course than immediate surgery. Most of the strangulated hernias in children were found to be under this two year age group and most often under three months. Emergency operations in this group carry a much higher mortality than elective procedures.

Although pediatric surgeons are agreed on the early operative approach, this attitude is not as widespread as it should be. Many infants are still being carried along by "conservative" means by pediatricians, generalists, and surgeons for the fears that early operation may be too dangerous and difficult. It is true that many times inguinal herniorrhaphy in the newborn or infant is not easy, but the risk of delay far outweighs any advantages obtained by waiting until the child attains sufficient size. It has been the experience of the author that irreducibility, either temporary or permanent, occurs in one-third of inguinal hernias in infants. Fortunately, the majority of these, after a short period of careful treatment can be reduced, but surgery on an infant with an irreducible hernia can be quite hazardous—not to mention the sword of Damocles than hangs over the heads of the parents.

The diagnosis of inguinal hernia is most often made by the mother, who notices the appearance of a mass in the groin. Occasionally, the hernia is found by the pediatrician after a routine but thorough examination. Often when the surgeon first sees the child, the hernia is not prominent and may not be palpable. Careful examination in practically all instances by the method described by Gross² will result in the discovery of a sac. By gently rubbing the fingers over the cord as it lies at the external ring, the sac may be felt to glide or slide back and forth under the fingers. Fortunately, this feeling of silkiness is particularly evident when the sac is empty, in fact depends upon the gliding of its opposing surfaces. Examination through the external ring as performed on adults does not apply here. Occasionally a dilated internal ring may be palpated about the mid portion of the inguinal ligament at about the prominent transverse lower abdominal crease. Rarely one will not be able to palpate a mass or sac and in this instance, forcing the baby to cry or seeing the baby at home when the hernia is down will give the diagnosis. When none of these have been successful in demonstrating a hernia, the author has no hesitancy in exploring the inguinal area if he feels that the mother's history of a recurrent inguinal mass is reliable.

Hernia Serious when Irreducible

When a hernia has become irreducible, it represents a serious matter. The great majority of these, treated properly, however, will reduce in one to three hours. Gentle squeezing of the mass may express enough gas proximally through the internal ring to allow the intestines to slip back into the abdomen. In any instance of irreducibility, the sac contains bowel and not omentum as in the adult. Attempts at reduction are doomed if there is any coughing, sneezing, crying, or tenseness of the infant. It is far better

to raise the foot of the bed (at times carefully tying the baby's feet to the end of the bed to prevent slipping forward), apply a well covered ice bag to the inguinal area, and heavily sedate the patient with a barbiturate, paregoric, or morphine. If, after about three hours, the mass is still irreducible, the patient is operated upon. Waiting to make a diagnosis of strangulation is risky. If the hernia does reduce, this episode must be taken as a warning and plans are made to operate upon the baby in about 48 hours. Even at that late date the tissues may be quite edematous and make the dissection more difficult.

It is probably pertinent at this point to offer a plea to disregard the terms incarceration and strangulation as clinical entities. These terms are confusing and should be reserved for the actual appearance of the hernial contents at the operating table. It is not necessary to differentiate clinically between incarceration and strangulation. Usually this distinction is not possible and one may be tempted, at times, to procrastinate. A far better approach is to utilize the terms reducible and irreducible. Obviously, an irreducible hernia may or may not have its blood supply jeopardized, but the diagnosis of irreducibility is basis enough for immediate surgical exploration.

Hernia Most Often Found in Males

As is well known, the hernia is most often in the male, invariably on the right and is always indirect. This has been explained by the delayed descent of the right testicle and delayed closure of the processus vaginalis. The hernia is frequently associated with a hydrocele, either of the cord or tunica vaginalis, and often associated with an umbilical hernia. Seldom does the latter require repair under one year of age. Occasionally a recurrent mass in the inguinal area or scrotum will prove to be a hydrocele communicating with the peritoneum through a narrow opening. Inasmuch as this situation requires repair, a mistaken diagnosis of hernia is of no great consequence. Undescended testicle is a different matter. In the great majority of instances, an undescended testicle is associated with a hernial sac, but early repair of the malpositioned testicle is not justified at an early period. This requires careful dissection of extremely delicate tissue about the cord structures and for this reason repair is delayed until the child is six to ten years of age. In addition to the difficulty of the procedure is the fact that many of these testicles will eventually descend spontaneously. If irreducibility of the accompanying hernia occurs, however, this situation must be treated as any other inguinal hernia.

The question arises as to whether or not bilateral inguinal exploration should be done if a contralateral hernia cannot be determined clinically. Many authors have reported finding hernial sacs on the contralateral side after failure to demonstrate a hernia here prior to surgery. A high percentage of infants have hernial sacs in which no clinical evidence of hernia can be demonstrated. Since the incidence of bilateral sacs diminishes rapidly after the first year, it is clear that most of these peritoneal processes become obliterated with time. Consequently the finding of a sac on the opposite side does not mean that a clinical hernia would have developed. For the small number of hernias that might be prevented by this bilateral approach, a large number of unnecessary explorations will be done. The author does not recommend bilateral explorations if the hernia is right sided; if the hernia is left sided contralateral exploration can be justified here since this child is much more likely to develop a right sided hernia.

There are few contraindications to early surgery and by early surgery is meant operation when the diagnosis is made. It is preferable not to proceed with elective procedures during the first two weeks of life, however. If necessary, even prematurity does not contraindicate surgical intervention. It must be said that early surgery on infants requires expert anesthesia. Ordinarily the choice of anesthesia is left up to the anesthesiologist, but usually is open drop ether. Although under some circumstances local anesthesia may be used, as in prematures, general anesthesia is almost always possible and certainly desirable.

The infant should be kept warm during surgery since he loses heat rapidly. This may be accomplished by placing carefully wrapped warm water bottles on either side of him or by using a specially constructed box containing an electric bulb, placed on the operating table.

Technique

Exposure of the inguinal area is obtained through a transverse incision in the prominent skin fold of the upper groin. This places the incision over the internal ring and will require some retraction to expose the distal area. The scar resulting from this incision is quite cosmetic. Infants have much more subcutaneous fat than the inexperienced operator is likely to expect. Occasionally the external oblique aponeurosis may be quite thin and delicate and be mistaken for the superficial fascia. After the external oblique is exposed, the fibers are split in their direction through the external ring. The flaps are retracted and held by an assistant with mosquito

forceps. The cord is raised and the sac is exposed by opening the cremasteric muscle. At this point the sac may be completely transected and the proximal portion removed first. It is well to remember that as the sac is freed from the cord some fibers of the transversalis fascia need to be dissected. The resulting defect in the posterior wall, though small, must be repaired. In all probability simple high ligation of the sac with its removal is all that is required for cure, but I have never been able to resist tightening the internal ring somewhat. Not as tightly as in the adult and not by suturing any structures to the inguinal ligament, but by plecting the transversalis fascia deep to the cord. Any attempts to suture the posterior wall to the inguinal ligament is not only unnecessary, but may prove harmful by compromising the integrity of that area by suture and tension. Attention is now directed to the remaining distal sac. This is removed with considerable care from the cord structures. At times the sac may extend down into the scrotum as a hydrocele of the tunica vaginalis and may or may not communicate with the proximal peritoneal process. Only about half of the sac on the anterior surface of the testicle need be removed. The remaining is left without suturing it either to the testicle or behind it. Usually the testicle is brought up into the wound, so one must exercise gentle handling of this organ to prevent marked post-operative edema or hematoma formation. Care is also taken to replace the testicle properly in the scrotum.

The next step is to approximate the external oblique aponeurosis over the cord and fashion a new external ring. The final phase is the closing of the subcutaneous tissues with fine catgut sutures of 5-0 or less. Although 5-0 silk has been used to this point, fine catgut is preferred for subcutaneous and subcuticular sutures (despite its slight fibrogenic properties). Rarely silk will extrude from the wound some weeks or months later and while not a

serious complication, will prove embarrassing to the surgeon.

No skin sutures are used. Instead a subcuticular suture of 6-0 chromic eye catgut results in a better scar and permits the wound to be sealed with collodion. As the collodion is drying the thighs are extended. If the thighs are flexed, the collodion may peel more readily when the child stands or kicks about.

Post-Operative Care

No specific post-operative wound care is necessary except to insist upon changing wet diapers as soon as possible. Shortly after the baby is returned to his room he is awake and playing. There is little, if any post-operative pain and pain medications are not routinely prescribed. He is allowed small sips of water as soon as he has reacted well and after a few hours a mixture of half formula or milk and water is given ad lib until the following day. At that time he is placed on his usual routine and discharged from the hospital.

Within several days the collodion dressing has separated from the wound and when he is seen in the office in about a week, any remaining can be peeled off. In two or three weeks any edema or induration about the wound and scrotum will have disappeared and the wound by now will be well healed and quite inconspicuous.

Summary

This article is a general review of the author's experience with inguinal hernias in children to encourage early surgical intervention. Conservative pre- and post-operative care are mentioned briefly, while the preferred operative method is described in some detail.

348 West Ponce de Leon Avenue

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2. Gross, Robert E.: *The Surgery of Infancy and Childhood*, 452, 1953.

A.M.A. Meeting to Feature Special Session on Aging

A SPECIAL SESSION ON NEW concepts in aging will be held during the annual convention of the American Medical Association in Atlantic City, June 8-12.

This one-day session, to which all physicians are invited, will be held in Room C of the convention hall at 9 A.M. Wednesday, June 10, under auspices of the A.M.A. Committee on Aging.

The meeting is designed to present the practicing physician with a concentrated review of current thinking regarding health care of the aged, and to provide him with concrete health recommendations which he can translate to his own older patients.

Keynoting the session will be a series of panels devoted to Diseases Among the Aged, Nutritional Counseling, Promoting Physical Fitness, and Motivating the Older Person. Panel members will include Drs. David B. Allman, Leland S. McKittrick, Edward C. Reifenshtein, Irving S. Wright, Walter E. Vest, Jr., Frederick C. Swartz, Frederick J. Stare, Clive M. McCay, Margaret A. Ohlson, Henry A. Holle, Norman Lee Barr, Theodore G. Klumpp, Janet Wessell, Edward H. Williams, Ewald W. Bussee, Howard P. Rose, and Cecil Wittson.

ERYTHEMA MULTIFORME

A case report with a review of the literature of the past five years.

Darnell Brawner, M.D. and Vincent J. Cirincione, M.D., *Savannah*

ERYTHEMA MULTIFORME is an acute inflammatory disease characterized by polymorphous exudative, bright or dark red, and symmetrically distributed lesions. The main sites of predilection are the upper part of the face, the neck, forearms, legs, and the dorsal surfaces of the hands and feet. On the forearms, hands, and feet the lesions are usually of the iris type.

Hebra originally described the disease: his conception of this disease has gradually been enlarged until the term now is applied not only to the simple idiopathic recurrent eruptions, usually limited to the hands, forearms, face, and neck which lasts for a few weeks but also the symptomatic type. In this the manifestations are clearly of a toxic or infectious nature and they are often more severe and more lasting.

Varieties of erythema multiforme are named according to the more prominent features of the lesions composing the eruption; erythema annulare, erythema bullosum, erythema circinatum, erythema iris, erythema nodosum, erythema papulatum, erythema perstans, erythema urticatum, and erythema veciculosum are some.

The symptomatic types of erythema multiforme include polymorphus erythematous vesicular and bullous toxic eruptions that develop as manifestations of serum sickness, drug eruptions, or systemic or visceral disease, such as infectious mononucleosis, brucellosis, pericarditis, arthritis, nephritis, epidemic meningitis, gastrointestinal upsets, or following severe sun burn or poison ivy dermatitis. A few cases have been reported which seem to result from uterine disorders, fetal necrosis and other severe disturbances of the female reproductive organs. During pregnancy erythema multiforme is often of the gravest significance and may necessitate

abortion. In the symptomatic type the distribution tends to be more profuse on the trunk and face; the eruption is bright red; and irises are rare.

Case Report

In view of the fact that erythema multiforme in pregnancy apparently is a rare disease, we have decided to report the following case of erythema multiforme bullosum in pregnancy.

The patient, a 19 year old Primagravid Caucasian woman, was first seen September 2, 1958 complaining of a severe persistent itching rash. She was 38 weeks pregnant at the onset of the dermatitis, her expected date of confinement being September 9, 1958. The patient had enjoyed excellent health all of her life and the pregnancy had been uneventful until five days ago. At the onset of symptoms she had been treated with Benadryl® and triamcinolone. The rash spread steadily, as had the intensity of the pruritus. There was no past history of significance and there was no history of drugs, other than the usual vitamins and minerals given in pregnancy. Examination revealed a fair skinned female with an extensive grouped papular urticarial dermatitis especially severe on the distended abdomen, buttocks, posterior thighs legs, arms, and forearms. A tentative diagnosis of herpes gestationis papular urticarial type was made and the patient was advised to continue her oral medication of Benadryl® and triamcinolone.

The symptoms increased in severity in spite of medication and three days later she had a diffuse generalized dermatitis. The lesions were now seen on dorsum of arms and legs. Typical iris lesions and areas of ecchymosis were noted. Papular urticarial lesions were now confluent and some of the iris lesions were beginning to show vesicles. The patient had crusting vesiculation of the conjunctiva

and crusting of the lids. The tongue had ulcerations and the oral mucosa and lips were eroded and crusted. The vaginal mucosa was similarly involved.

The patient was hospitalized. On admission her temperature was 100.6, complete blood count—normal, urine—normal, sedimentation rate 8, the Kahn negative, and the chest plate was within normal limits. The patient was treated with adrenocorticotrophic hormones—80 units daily, 16 mg. triamcinolone daily, and 2 cc. immune globulin daily.

The dermatitis became progressively worse with large bullae developing on arms, legs, and back. At no time did the patient appear systemically ill.

On the fourth hospital day the patient went into labor spontaneously, and because of a prolapse of the umbilical cord, a caesarean section was done. A normal and apparently healthy child was delivered, without further complications and the placenta showed no pathology. The next day the patient looked better and improved progressively. She was weaned of her medication but obviously they had not helped. The patient had an uneventful recovery from the caesarean and was discharged 12 days post-operatively. On discharge the dermatitis was involuting rapidly.

The literature for the last five years has had little on erythema multiforme in pregnancy. It would almost seem as though the obstetrician ignores everything but the pelvis and the dermatologist everything but the skin.

Greenhill in the 11th edition of the *Journal of Obstetrics* states: "Erythema multiforme; this is a toxic eruption with a predilection for the extremities of mouth and neck. Its presence is sometimes an indication for therapeutic abortion."

Holland and Vogel reporting in the *Pennsylvania Medical Journal* noted that skin diseases are more

frequent during pregnancy and mentioned erythema multiforme only under the heading of differential diagnosis.

Davis in the *British Journal of Dermatology* under Prurigo annularis states: "This eruption tends to appear or be aggravated during pregnancy."

Crawford and Leeper in a review of 50,000 deliveries at Boston Lying In Hospital during a 20 year period found the incidence of erythema multiforme to be 0.010 per cent while a private practice incidence in 6,212 pregnant women was 0.047 per cent. His five patients with erythema multiforme presented the greatest association with complications of any of the dermatological diseases of pregnancy.

A case of erythema multiforme bullosum in pregnancy is presented, in view of the rarity of the disease. The cause of the disease was not apparently altered in any way by extensive therapy with anti-histamines, cortisone, adrenocorticotrophic hormone, immune globulin, and antibiotics. The termination of pregnancy caused a rapid involution of the symptoms.

The dermatitis appeared to be a toxic manifestation to the pregnancy itself.

2512 Habersham Street

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The Medical Care Dollar

THE COST OF MEDICAL CARE is widely discussed nowadays, often with more heat than light. So a break down of what happens to the medical care dollar, published in a late issue of the American Medical Association News, is of very wide interest.

The comparison is made between 1929 and 1957. In the former year, physicians received 32.6c out of the medical care dollar—but in 1957 their proportion had fallen to 24.5c. The dentists' also dropped, from 16.4c to 11.3c. The proportion spent for drugs was the same in both years—20.6c.

Where did all the rest of the dollar go, then? The answer is that the share taken by hospitals just about doubled—from 13.7c to 25.8c. The same thing was true of health insurance, which rose from 3.7c to 7.1c. This certainly does not mean that the hospitals and the health

insurance people are prospering unduly at our expense. The standards of hospital care have risen tremendously, a much larger and more complex list of services is needed and provided, and costs can't help but reflect that fact. The scope of health insurance also has been vastly widened since 1929.

The News provides some more significant facts. Total medical care spending in 1957 took 5.3c out of the consumer expenditure dollar, as compared with 3.7c in 1929. That is a substantial increase. But, in return for it, we have been given medical service infinitely superior to that of the past. Killer after killer has been subdued by the medical arts. We live years longer than we used to. And our lives are happier, healthier, more productive.

Dawson News

OBSERVATIONS, OBLIGATIONS, AND OUTLOOK

LEE HOWARD, SR., M.D., *Savannah*

Presented May 18, 1959, Augusta

THIS PART OF YOUR President's address is written April 17th and does not include a summary of achievements during the past year.

This address is divided into three categories:

- I. OBSERVATIONS
- II. OBLIGATIONS
- III. OUTLOOK

Observations

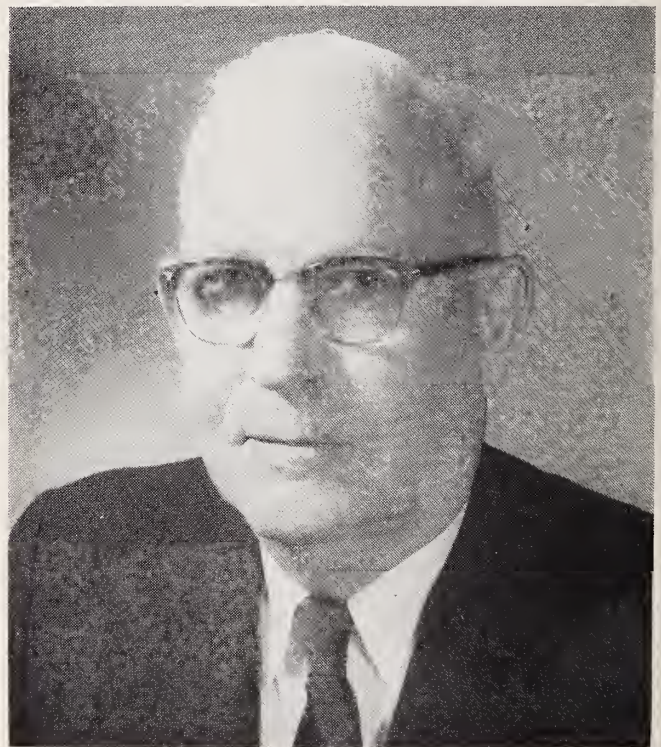
Soon after I assumed office, following several visits to the Headquarters office, I learned of the many inadequacies in equipment and space in our present location, a number of cut-up rooms in the basement of the Academy of Medicine. The space and its arrangement does not afford an office, desk, or any sort of facility for the President and Secretary-Treasurer, and there is no storage space of any sort. This need has been partly met by purchasing a desk, chair, and files that are shared by the President and the Secretary-Treasurer.

I also noted the very inadequate facility for holding meetings at the Headquarters, an old table and eight or ten very old, uncomfortable chairs. Council has approved purchase of a suitable conference table and chairs, but the purchase has not been made up to this time.

My reaction in attending most of the district meetings to which I have been invited is that most of them are poorly attended, but the programs have been good and well received. About half of the districts have failed to notify the President or Headquarter's office of their meetings.

Other observations after attending all Council and many Committee meetings have been very

happy ones. The Council and main Committees have continued their enthusiasm and almost 100



LEE HOWARD, SR.
PRESIDENT, 1958-59

per cent attendance has been maintained for the past three or four years. Together with all of your officers, I have been impressed with the fact that the Medical Association of Georgia is now a large organization and well coordinated.

Obligations

Time would not permit an enumeration of the

many new and perplexing obligations that are now facing physicians, whether they be teachers, in public health, armed services, or private practitioners. These obligations, while they primarily concern the service to patients, should be supplemented with obligations to the hospitals, community, state, nation, the free world, and now, outer space.

Patient obligations are no longer limited to asking a few questions, looking at the tongue and prescribing a few pills. The physician is not only obligated for his best effort to meet the patient's immediate need with diagnosis and treatment, but he is also responsible for the services the patient receives in hospitals or other institutions. This should include the patient's pocketbook, to see that he is not exploited or overcharged by hospitals or institutions.

In the community, the physician should be a leader, especially in matters concerning the public health or health of the community. He should also assume leadership when possible and support all worthy community activities.

We have these same obligations as groups, county societies, MAG, and AMA. Of course, a primary obligation is better and possibly more medical

schools. A proper evaluation and affording of medical services to smaller communities. There has been, and is, a shortage of the ever-increasing tools of the medical profession: medical technologists, nurses, secretaries, and hospitals, all of which are an integral part of the practice of medicine. There is some argument as to which was first, the chicken or the egg, but I do not think there is any argument as to which was first, the physician or the hospital or the physician or the public health services, all of which have been organized and perpetuated by physicians.

Outlook

Our chief objectives would seem to be: first, adequate quarters and facilities for conducting the rapidly increasing work in the Headquarters offices; second, proper joint committees to iron out some of the difficulties between physicians and hospitals; and third, to promote the type of leadership that will encourage good will and teamwork within the Association.

With adequate quarters and equipment, and a continuation of the present *esprit de corps* and hard work, the outlook for the Medical Association of Georgia is bright!

108TH ANNUAL SESSION OF AMA, JUNE 8-12

SOME 15,000 PHYSICIANS WILL gather in Atlantic City, N. J., June 8-12 for the 108th annual meeting of the American Medical Association.

Besides physicians, the meeting will be attended by residents, interns, nurses, technicians, students, and physicians' wives and members of their families.

The five-day convention—the largest medical meeting in the world—is being held in Atlantic City for the 16th time. The first meeting was held there in 1900.

Doctors will have the opportunity to catch up on hundreds of aspects of a rapidly-changing medical world. This information will be presented in the form of scientific exhibits, lectures, motion pictures, panel discussions, televised surgical procedures, and industrial exhibits.

New medical research findings and methods of handling daily medical problems will be reported by 500 physicians in scientific papers or participation in symposium and discussion groups.

There will be over 300 scientific exhibits and a similar number of industrial exhibits on display at the famed Convention Hall. The latter group will be exhibited by pharmaceutical houses, medical equipment firms, and other manufacturers.

The House of Delegates will meet throughout the week in the Traymore Hotel, headquarters for the meeting. The 20 scientific sections of the A.M.A. and five government medical services will also be represented in the House.

First order of business for the House will be the selection of a physician to receive one of medicine's highest honors—the Distinguished Service Award. He will be elected from three persons, whose names are submitted by the Board of Trustees. Nominees are screened by the Board from names submitted by the general membership.

The opening session will be addressed by Dr. Gunnar Gundersen, La Crosse, Wis., outgoing president, and his successor, Dr. Louis M. Orr, Orlando, Fla.

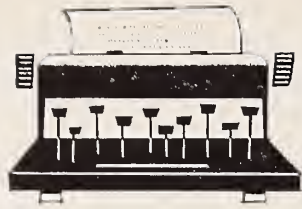
For the fourth year, high school students who have won special A.M.A. awards in the National Science Fair will show their prize-winning work at the scientific exhibit.

The annual film program will be highlighted by the presentation of 60 medical motion pictures.

The Woman's Auxiliary to the A.M.A. will hold its meeting Tuesday through Thursday. Representatives of the 75,000 members—all doctor's wives—will discuss their program in sessions at the Chalfonte-Haddon Hall.

Other sidelights of the meeting will be the special art exhibits including that of the American Physician's Art Association, and the 43rd annual American Medical Golfing Association tournament.

For advance hotel and meeting registration information, contact the Convention Services Department, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.



editorials

The Rise of Malpractice Suits

CLAIMS FROM PERSONAL DAMAGE suits paid to patients by physicians, or Liability Insurance Companies covering physicians, are totaling some \$50,000,000 annually in this country. This unbelievable figure results from an enormous increase in the judgments rendered by the courts and a ten fold increase in the number of claims made. No longer is a doctor secure from such hazards by rendering services of "usual and ordinary quality." Many and large claims are now being paid where there is no question of deviation in professional judgment or skill. Decisions by courts and juries would seem to be more and more influenced by the skillful display and adroit presentation of the plaintiff's attorney rather than a sober consideration of the facts.

We live in a "give-away" world. Radio, newspaper, and television presentations abound in the exciting possibility of the same plain-citizen receiving a fabulous wind-fall for a lucky guess or thought. Every auto accident has within it the possibility of each participant receiving a life-time income from a damage suit. The professional liability suit and judgment rest in this same category. It would not seem to be a condemnation of the medical practitioner or a deterioration of professional skill.

If the quality of medical care has not recently deteriorated and if plaintiffs judgments are substantially influenced by skillful court dramatics, then our best chance of curtailing this costly trend is to prevent the claims rather than to defend the suits. The only alternative, if the present trend continues,

will be to practice medicine without the protection of liability insurance. In a few years, the cost of this insurance will be prohibitive.

Medical journals continue to publish frequent articles discussing professional liability, and its ramifications. They are well worth the reading. As most doctors in Georgia now realize we have an insurance program for liability which is being jointly administered by the insurance carrier and the Medical Association of Georgia. All claims or potential claims are being investigated jointly by the insurance company and representatives of the Medical Association. After three years in this endeavor a certain pattern is becoming clear; so clear, that it seems worth while for emphasis in an effort to reduce the number of liability claims.

Two factors seem basic in the creation of a malpractice claim: (1) There is a deterioration in the doctor-patient relationship. Repeatedly in investigations it is found that a patient, dissatisfied with the results obtained will return to the doctor for discussion and explanation. The doctor will be short or less than solicitous with the patient. In spite of this the patient will return two or more times, still seeking the interest and sympathy of the doctor. Only after several rebuffs will the patient seek advice from another doctor. (2) Improper advice given by a doctor concerning the judgment, skill, or results obtained by another doctor.

When the above mentioned dissatisfied patient is unable to get a satisfactory explanation or even a

sympathetic ear from the original doctor, the advice of another is sought. This second doctor may make another major mistake leading to a malpractice claim. Unless we know all the circumstances surrounding what appears to be a bad result, we should withhold our opinion to the patient until these facts are available. The most accurate source of all the facts is a discussion of the case with the original doctor. This simple procedure would cause a significant reduction in the number of liability claims filed.

In our daily work we must all realize that a new menace has arisen which may significantly retard the

active progress of medicine. We could conceivably reach a point when new drugs and new procedures could not be used. This delay in usage would not come from lack of scientific data, but from a fear of professional liability.

If three years of joint administration of our professional liability program has taught us any preventive measures, they are these: always be solicitous and sympathetic with a patient who thinks he has gotten a bad result, and never criticize a colleague until you have all the facts.

Cancer Research Today

NEARLY EVERY DAY WE READ in magazines and newspapers of some advance in a phase of cancer research. For many physicians it is difficult to assay the significance of these reports. This is particularly true for those physicians who do not read certain medical journals or take the time to investigate such reports. Of course, most of the articles are written by non-medical people for the general public. What on the surface might appear to be a significant advance, on careful reading or investigation may be found merely to reiterate something already known or a procedure or treatment which is effective only in animals.

As an example of this type of reporting, the following is a good example, "Medical researchers seem to have uncovered the secret of cancer's ability to grow at its victim's expense. They now can prevent an implanted cancer from growing in a rat, and he can let a rat cancer get started, then stop it. This suggests that early cancer in humans can be stopped and that malignant cells unavoidably left in the system after cancer removal can be kept from growing." The article continued in an effort to explain the experimental approach used to ascertain the above information and that it has not been tried in humans. Casual reading of the headlines for this article, "Labs Detect Secret of Cancer Growth," would lead one to believe that the fundamental answer to cancer growth had been found. Reporting of this nature oftentimes leads to unfounded hope in patients, families, and the physicians, which could be avoided better by less and/or more critical reporting of such investigations in non-medical channels.

At the present time researches in cancer along

various lines such as cause, diagnosis, and treatment are being pursued extensively. Millions of dollars are being spent annually to advance our knowledge of growth and cancer. This is proper since it appears that only through extensive and expensive investigations will we ever be able to increase our knowledge to the point of possibly solving the problems inherent in the disease cancer.

Concerning the cause or causes of cancer, it is well known that cancer in animals such as chicken leukoses, mouse leukemia, and others can be produced by viruses, but so far no malignant tumor in man has been shown conclusively to be caused by a virus. We know that certain human cancers have a hereditary background, such as retinoblastoma, also that certain chemical and physical agents such as tar, aniline dyes, and ionizing radiations are carcinogenic. Why or how these agents produce cancer is still not known. We do not know the cause or causes of most human cancers.

It has been hoped for years that investigations would lead to a universal test for cancer, such as the Wasserman test used in detecting syphilis. A successful procedure has not been found up to the present time and the likelihood of perfecting such a test is highly remote due to the multiplicity of cancer types.

The treatment of cancer is the phase with which most practitioners and all patients are most concerned. Certainly, cures for diseases may be perfected without knowledge of cause. This is why such great efforts have been expended in seeking a cure for cancer. This is what the physician would like to offer his patient. In recent years new agents have

Continued on page 230

EDITORIALS / Continued

been found which destroy cancer cells, such as nitrogen mustard, radioactive iodine, cortisone, estrogens, androgens, and others. However, these agents are cell poisons, as are certain other drugs. As yet, we have not found any substance which selectively destroys only cancer cells and does not harm the normal cells. This has left us with certain chemical substances which may produce varying degrees of palliation, but not permanent cures.

The millions of dollars already spent for cancer research and the slight advance in finding a satisfactory curative treatment may leave one with a high degree of pessimism. However, it must be realized that a study of cancer involves an approach to life itself. Even though the answer to life may be unfathomable, continued investigations by the combined efforts of many disciplines in time may give a

satisfactory answer to the problem. Research is worthwhile in itself, since much new knowledge may be gained though the immediate problem is not solved. Certainly, it is only through continued research that we might expect any advances. The patients reap the benefit of the investigative efforts of chemists, physicists, mathematicians, biologists, and research physicians which the practitioner offers his patients through the synthesis of this knowledge. We all are deeply indebted to the researcher who in so many instances pursues his work with little personal gain.

The statement *"So far all is on schedule, but the future is unknown; we have no estimated time of arrival" seems apropos to the status of cancer research as we see it today.

John T. Godwin, M.D.

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Committee Studies Milledgeville

GOVERNOR ERNEST VANDIVER has called on the Association for assistance in solving problems that have arisen in regard to the Milledgeville State Hospital. On March 8 he asked President Lee Howard to appoint an MAG committee to investigate the specific charges that had appeared in the newspapers and to study the medical and psychiatric programs at the hospital in general.

Dr. Howard appointed W. Bruce Schaefer, Toccoa, Chairman of the Committee. Other members appointed were John Bell, Dublin; Rives Chalmers, Atlanta; Corbett Thigpen, Augusta and Hugh Wood, Atlanta.

The Committee organized at Athens on March 13. It met in Milledgeville on March 15, March 18, and April 7, and in Atlanta on March 27 and April 19. As the *Journal* went to press, plans were for the Committee to make their final presentation of the report to the Governor on April 23 at the Capitol in Atlanta.

Rarely in the history of the Association has a Committee of physicians been called on for so much work in such a short period of time. The members of this Committee are to be congratulated for their willingness to assume this important task. They

have worked long hours and have come up with a comprehensive report on our state mental institution.

The Committee members have borne their own expenses and MAG assumed the other expenses of the study, such as legal fees, court reporter's bill and miscellaneous expenses.

The MAG is proud of this opportunity to serve the people of our state. We have a real duty to perform in the way of informing the public on all health and medical matters. In the area of mental health, it is fitting and proper that physicians should assume leadership and assist the Governor and other public officials in improving the care and treatment of the mentally ill of our state.

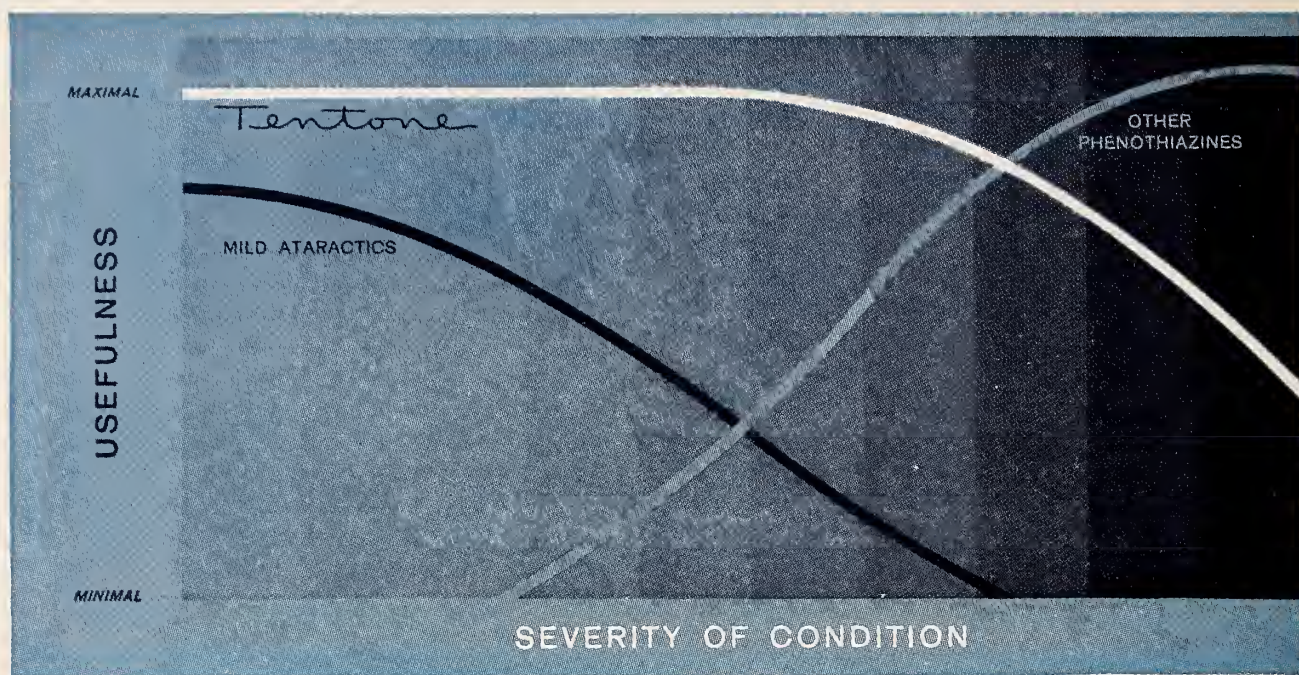
It is believed that the report of the MAG Committee to study the Milledgeville State Hospital will have far-reaching effects on the development of a modern psychiatric program at Milledgeville. If so, the Association will have fulfilled its purpose toward the "betterment of public health."

It is sincerely hoped that the Governor and other public officials will call upon our organization for advise and counsel in the future. We have shown that MAG stands ready and willing to serve.

ANNOUNCING



A HIGHLY EFFECTIVE
TRANQUILIZER FOR
EXTENDED OFFICE
PRACTICE USE



**POSITIVE CALMING
ACTION ADAPTED
FOR LOWER RANGE
OF EMOTIONAL
DISORDERS**

The development of TENTONE® Methoxypromazine Maleate *Lederle* does not duplicate primary function of existing tranquilizers. TENTONE fills the need for a practical, potent agent for extended use in everyday practice (as illustrated above).

Action of TENTONE Methoxypromazine Maleate approaches that of the strong phenothiazines without their drawbacks. Calming response is positive and rapidly apparent to both patient and physician. However, as a basic phenothiazine modification, TENTONE allows full therapeutic application in the mild and moderate range of anxiety-tension and somapsychic disorders most usually seen in general practice.

**EXCELLENT
TOLERATION—
MARKED
REDUCTION IN
COMPLICATIONS**

Incidence of untoward reactions is exceptionally low and approximates the mild ataractic drugs. Reduction in sensitivity reaction, intestinal distress, blood, brain or liver toxicity is striking, particularly in the low dosage range. TENTONE exhibits greater freedom from depression and drug habituation. Physical and psychic orientation is usually preserved. Occasional drowsiness may be encountered, particularly in higher dosages. In moderate to more severe cases, this sedative effect may be desired.

TENTONE has thus been described as one of the easiest tranquilizers to handle in office practice. In indicated cases, the physician may be relieved of the patient's unnecessary concern over his own illness. In contrast to the previous types of drugs, complaints over induced distress or inadequate benefit are rare.

WHEN MORE THAN
MILD SEDATIVE
EFFECT IS DESIRED

Consequently, TENTONE is more useful than other ataractic drugs in two areas: (1) mild to moderate conditions—when more than mild sedative effect is sought, (2) middle range of moderate to severe cases—when less than psychopathology is involved.

Indications include ■ common anxiety-tension states ■ obsessive-compulsive behavior ■ neurosis ■ depression ■ situational anxiety and hysteria

And the emotional components of: ■ agitation ■ restlessness ■ tremors ■ insomnia ■ alcohol- and drug-withdrawal syndrome ■ hyperkinesia ■ prenatal anxiety ■ rheumatic disorders ■ dermatoses ■ menopausal syndrome ■ premenstrual tension ■ peptic ulcer, other g.i. disorders ■ asthma, other allergy ■ multiple sclerosis, arteriosclerosis ■ malignancy, other progressive diseases

POSSIBLE
POTENTIATION OF
ANALGESICS
AND NARCOTICS

Since tranquilizing drugs may potentiate the action of pain-relievers, sedatives, and barbiturates, they should be used with caution in conjunction with them, or to achieve a greater response to these drugs in various conditions when desired. They may also be useful in reduction of effective dosage to better tolerated, or non-habituating levels.

ADAPTABLE
LOWER DOSAGE
RANGES

Dosage must be individualized to severity of condition and response desired.

In mild to moderate cases: varies from 30 to 100 mg. daily.

In moderate to severe cases: from 75 to 500 mg. daily.

In psychotic or institutionalized patients, TENTONE may be useful as a substitute when toxicity precludes effective dosage of other phenothiazines, or as maintenance after hospitalization. Dosage may range from 100 to 1500 mg. daily in divided doses.

Supplied: 10 mg., 25 mg. and 50 mg. tablets



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

POPULATION WANTS TO CHOOSE OWN DOCTOR

MORE THAN THREE-FOURTHS of the population of the United States want to choose their own doctor.

In addition, they want to assume all or part of the responsibility for paying their doctor bills.

These are among the findings in a survey conducted among a sampling of the adult general population by Opinion Research Corporation, Princeton, N. J., for the American Medical Association.

The purpose of the study was to explore attitudes about the choice of physicians. The study also showed that:

Eighty-eight per cent of the population believe the right to see the same doctor regularly is of vital importance.

Eighty-nine per cent believe that medical care in this country has improved over the past 20 years. Half of these persons ascribe the improvement to more and better research and advances in medical science.

Seventy-six per cent of the people said they wanted to choose their own physicians; 13 per cent saw no difference in whether they or someone else chooses their physician; eight per cent preferred to have someone else choose, and three per cent had no opinion.

In answer to further questioning, 93 per cent of those surveyed felt that free choice would give them more confidence in the doctor; 84 per cent thought doctors would take a more personal interest in them, and 79 per cent believed they would have less trouble getting the doctor to make a home call.

Concerning the right to see the same physician all the time, 88 per cent felt this right to be very important.

Of the 12 per cent who did not feel such continuity to be of vital importance, eight per cent saw no difference in whether or not they saw the same doctor every time, and four per cent gave other comments.

In answering still another set of questions, 93 per cent felt such continuity would give them more confidence in the doctor; 92 per cent thought doctors would take a more personal interest and 84 per cent believed they would have less trouble getting a doctor to make a house call.

When queried about the main advantages of a regular doctor, those interviewed gave a variety of reasons. 62 per cent cited the physician's knowledge of their medical history. They said, "He knows your system inside and out from dealing with you regularly; he knows what you've had."

Also mentioned by 30 per cent was reliability on emergency calls; confidence in the physician by 21 per cent, and a closer relationship between doctor and patient by 18 per cent.

Concerning the payment of medical bills, a total of 79 per cent wanted to assume all or part of the responsibility for paying their doctor bills either by direct payment or by paying part of insurance premiums.

The 79 per cent breaks down into the following: 16 per cent for paying all doctor bills directly; 16 per cent for paying all costs of insurance plans, and 47 per cent for paying part of the cost of an insurance plan. The remaining 21 per cent favored someone else's paying the bills.

GLAUCOMA IDENTIFICATION CARD

A GLAUCOMA IDENTIFICATION CARD for nationwide distribution has been announced by The National Medical Foundation for Eye Care as a major public service project.

The card, similar in purpose to the diabetes identification card, will alert examining physicians that the patient has glaucoma and is using drugs.

The names of the patient and of the ophthalmologist who prescribed the drugs, appear on the card, together with the prescription. This information alerts the examining physician to the patient's condition and the treatment he is undergoing and forestalls the use of any contra-indicated medication by the examining physician.

Glaucoma patients who run out of their prescribed medicine while away from home are able to get a new supply quickly, without interrupting

treatment, an important factor in glaucoma therapy.

In addition to the prescription for drugs, the glaucoma card also carries the spectacle prescription of the patient, which enables him to replace broken lenses when away from home.

The National Medical Foundation for Eye Care glaucoma cards were printed as a public service by Abbott Laboratories, and are being initially distributed to physicians by the Laboratories. Packets of the cards may be obtained by writing to the Foundation office, 250 West 57th Street, New York 19, New York, or directly to Professional Services, Abbott Laboratories, North Chicago, Illinois.

It is estimated that one out of eight blind persons has lost his sight from glaucoma, and an estimated million men and women over 40 years of age are suffering from undetected glaucoma.

current clinical concepts

Traumatic Hematuria as a Manifestation of More Serious Renal Disease

IT IS IMPORTANT TO investigate hematuria which is associated with common accidents that do not otherwise often cause gross hematuria. Relatively minor falls and blows associated with gross hematuria require urologic X-ray investigation.

The New England Journal of Medicine, Vol. 260, No. 14, April 2, 1959.

Survival in Lung Cancer

SURVIVAL RATES FOR PRIMARY lung cancer are indeed discouraging. Inasmuch as the etiological factors are either unknown or debatable, the only sensible avenue of approach to improve the survival rates is periodic X-ray examinations of the chest in asymptomatic persons. The current anxiety about radiation hazards is theoretical and must not interfere with detection of early lung cancer lesions.

The New England Journal of Medicine, Vol. 260, No. 15, April 9, 1959.

G.I. Protein Loss in Idiopathic Hypoproteinaemia

IN FOUR CASES of so-called idiopathic hypoproteinaemia there was high albumin degradation (hypercatabolism), and radio-active polyvinyl pyrrolidone revealed pronounced permeability to high-molecular substances in the gastrointestinal tract.

The hypoproteinaemia was due to loss of protein in the lumen of the gastrointestinal tract, constituting a sign of disease in the system (hypertrophic gastritis, disease of the small intestine). In other gastrointestinal diseases involving hypoproteinaemia (cancer of the stomach, sprue) this sign may be of the same genesis. Lancet, 1959, 1: 327-330.

The Surgeon and the Law

The care physicians will in the future feel able to give patients may depend on a real awakening of the public conscience relative to unjustified claims. If it comes to pass that physicians must underwrite the use

of advanced diagnostic techniques and radical but promising methods of treatment, the patient, and medical science will be the loser. Physicians will hesitate to assume responsibility in a case where the prognosis is poor.

Forte, Felix, S.J.D., LL.D., J.D.

Rehabilitation of the Ulcerative Colitis Patient

EMPHASIS WAS PLACED on the feasibility of the one stage operation on patients for advanced ulcerative colitis. Eleven patients so managed all lived and did well. There were several deaths among those patients who had the stage procedures and the morbidity was greatly increased. The ileum was sutured to the skin and subcutaneous tissue with fine silk.

Hamilton, Joseph E., Chief of Surgical Service Veterans Administration Hospital, Louisville 2, Ky.

Bilirubin Breakdown Product of Hemoglobin

BILIRUBIN IS FORMED in the reticuloendothelial system as a breakdown product of hemoglobin. It is poorly soluble, not excreted by the kidney, and gives a delayed (indirect) reaction to the azo dye in van den Bergh test. This substance is carried to the liver where it is conjugated with glucuronic acid to become conjugated bilirubin. This new form is soluble in water, excreted by the kidney, and reacts promptly with the azo dye (direct) in the van den Bergh test.

This conjugated bilirubin is excreted by the liver into the bile ductile system where it is carried to the intestinal tract. Here it is acted upon by bacteria to form an almost colorless group of compounds known as urobilinogen. Some of the urobilinogen is reabsorbed into the portal blood where it is taken back to the liver. Here a portion of the urobilinogen is resecreted with the bile. That part remaining in the venous blood is excreted by the kidney.

Ingelfinger, F. J.: Differential Diagnosis of Jaudice, Disease of the Mouth, (November) 1958.

Surgical Considerations of Peripheral Arterial Aneurysms: Analysis of 107 Cases

THESE ARE CAUSED BY arteriosclerosis, trauma, infection, or post stenotic abnormalities. They occur predominantly in the extremities and for the most part are located in the popliteal and femoral regions. Conservative therapy has been associated with subsequent complications in 50 per cent of patients followed from three to five years. Normal circulation in this group was restored in the majority of these patients.

Crawford, E. Stanley; DeBakey, Michael E.; and Cooley, Denton A., reprinted from the A.M.A. Archives of Surgery, (Feb.) 1959, Vol. 78:226-238.

Roentgenographic Diagnosis and Surgical Treatment of Basilar Artery Insufficiency

THIS ARTICLE RECORDS a successfully treated case (by thromboendarterectomy) of a 55 year old man whose illness began with a sudden attack of extensive paralysis and total blindness. Occlusion was complete on the right side and incomplete on the left being local-

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CLINICAL CONCEPTS / Continued

ized to a discrete plaque near the origin of the vertebral artery. The partially occlusive lesion was removed and normal blood flow was restored through the vertebral artery and hence through the basilar artery. Subsequently his vision returned and he could walk.

Crawford, E. Stanley; DeBakey, Michael E.; and Fields, William S., Houston, Texas, *The Journal of the American Medical Association*, Oct. 4, 1958, Vol. 168.

Arterial By-pass Below the Knee

THE GOAL OF OPERATIVE treatment of segmental occlusive disease of the femoral artery is to restore pulsatile blood flow in the lower leg. This restoration was accomplished in 86 per cent of 317 patients treated by the by-pass graft technique. These grafts for the most part were dacron-knitted fiber. Some 33 cases have been operated upon and late thrombosis occurred in ten of these 33 patients. Re-operation was performed in six patients with successful thrombectomy and graft replacement in two. Thus in 25 (76 per cent) of these 33 patients the by-pass grafts are still functioning with palpable pulses. Amputation has been necessary in only one instance, and this particular patient had pre-existing gangrene of the foot.

Morris, George; DeBakey, Michael; Cooley, Denton; and Crawford, D. Stanley, reprints from *Surgery, Gynecology, and Obstetrics*, March 1959, Vol. 108: 321-332.

Radiation Nephritis

A REVIEW OF THE pertinent literature indicates that nephritis is an unusual complication of radiation therapy. The reasons for its occurrence are not clear. However, there is some clinical evidence to suggest that renal insufficiency may develop only when both renal areas have been radiated with at least 2500 r (depth) and when less than one-third of the total renal tissue is outside the critical radiation field. Others have speculated on the possibility of unusual sensitivity of the young, growing kidney to radiation to explain the development of nephritis during infancy. In any event, the possibility of radiation nephritis should be seriously taken into account in planning abdominal X-ray therapy.

Fainting with Marsilid

MARSILID OCCASIONALLY CAUSES severe enough orthostatic hypotension that the patient may faint on standing. Also a number of cases of severe acute yellow atrophy of the liver have been reported.

Personal Communication: A. J. Merrill, M.D.

Nephritis and Pregnancy

WOMEN WITH CHRONIC glomerulonephritis are often sterile, may abort at 3-5 months, or have accidental hemorrhage in the last month of pregnancy. If they understand the risks, they may be carried through provided they do not have hypertension or reduction of

renal function below 50 per cent. Such patients as the latter should not become pregnant and if they do should be aborted. This author advises induction of labor at the 33rd week because of the danger of accidental hemorrhage. All authorities do not agree with this.

De Wardener: "The Kidney," Little, Brown & Co., Boston, 1958.

Lupus and S.B.E.

DISSEMINATED LUPUS IS A multiple system disease with such a variety of symptoms that a not infrequent complication may be overlooked, namely subacute bacterial endocarditis. This is particularly true if the patient already exhibits cardiac murmurs. Practically all of the symptoms and signs of S.B.E. can be mimicked by lupus and the former may only show itself as an apparent progression of the lupus. Only by keeping the possibility constantly in mind and watching for embolic phenomena can S.B.E. be detected.

Personal Communication: A. J. Merrill, M.D.

Tetanus

THE AUTHORS STATE that the annual national death rate on tetanus is between five and six hundred people. A plea is made for wide-spread use of tetanus toxoid and active immunization. Important factors in the treatment of clinical tetanus are, (a) neutralization of the circulation toxin, (b) adequate sedation to avoid spasm and convulsion, (c) early tracheotomy, and (d) constant medical attention.

Surg.-Gyn. & Obs., Vol. 107:143 (August) 1958.

Carcinoma Rectum and Colon

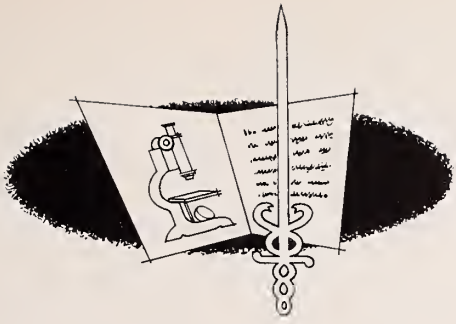
BLACK EMPHASIS THAT in his experience 50 per cent of the cases of carcinoma of the rectum and colon can be felt and an additional 25 per cent seen with the sigmoidoscope. This is the blind area for the radiologist and both rectal exams and sigmoidoscopes must be done. He deplored long antibiotic preparation of the bowel prior to surgery and stressed quick preparation (3-4 days) of a mechanically clean bowel and then operation. Unnecessary delay caused overgrowth of undesirable and often lethal bacterial invaders. Swallowed staphylococci might well cause the dangerous pseudomembranous enterocolitis.

From a lecture by Charles M. Nice, Jr., M.D. at the Atlanta Graduate Assembly.

Calcium Metabolism and Bone Changes in Sarcoidosis

CLINICAL AND BIOCHEMICAL STUDIES support the hypothesis that hypercalcemia in sarcoidosis is due to excessive sensitivity to vitamin D. Control of this complication may be achieved by a diet low in calcium and vitamin D, although cortisone is sometimes necessary.

Brit. Med. J. 1:248, 1957.



cancer page

THYROID CANCER

ANY CONSIDERATION of thyroid cancer must begin with two seemingly conflicting facts, namely; that, while the overall "cure-rate" is encouragingly high for all thyroid malignancies in comparison with cancer of other organs, yet much about its natural history and biology is not known or is poorly understood. Certain features of the disease are known and these include:

a. The extreme difficulty in making the diagnosis of malignancy before operation

b. The essentially benign nature in most instances of the well differentiated form of thyroid malignancy, as compared with the exceptionally fast growth and early termination of the undifferentiated or solid forms

c. The known tendency to grow locally, or to metastasize nearby, in preference to other parts of the body

d. The perplexing ability to cause death after a seemingly innocuous existence over a period of many years

The problem of early diagnosis of thyroid cancer (before operation) confronts all medical practitioners and encouraging progress can be reported. However, if more improvement is to be made, then the basic tenet of The American Cancer Society which demands that every unexplained tumor, mass, nodule, or swelling be investigated promptly, must be followed with conscientious diligence in dealing with lesions of the neck particularly in the thyroid area. Both incisional and excisional biopsy of an unexplained lesion in the area of the thyroid, frequent or routine use of frozen sections at each operation for nodular goiter, and particular studies of radio-iodine uptake, which is still in the experimental stage, as is the study of hormonal influence.

David Henry Poer, M.D., *Atlanta*

Punch or aspiration biopsy has also been used, but its unreliability has caused discontinuance in many clinics. With these aids, the surgeon is in a position to make a firm diagnosis of cancer before the final decisions concerning definitive procedures are made in approximately 50 per cent of all cases.

The gross disparity noted in the growth of various forms of thyroid cancer has not caused particular concern because the ones with low grade activity usually do well and the highly malignant lesions do not respond well to any form of therapy. The latter make up only a small percentage of the total (10 per cent to 20 per cent), and in 75 per cent of these death occurs within a matter of months.

The greatest difference of opinion regarding adequate treatment takes place in consideration of the large groups of papillary and alveolar carcinomas, with and without metastases to regional lymph nodes. Convictions run deep among the numerous writers on the subject, many with almost emotional overtones. There is no questioning the fact that the percentage of five year "cures," is high with all types of surgical approach, and actually the overt nature of the disease has caused many presumed "cures" by non-surgical methods to be reported. At the present time there are too few reports on record of late results (10 years and over), by any of the numerous methods of treatment, and any

Continued on page 236

Approved by Professional Education Committee, Georgia Division, ACS.

final decision concerning "radical versus conservative" methods will necessarily have to be deferred, but the surgeon must be warned to bear in mind the fact that the disease may lay dormant for many years and suddenly without cause burst forth in the same or some new location and that this delayed growth may cause the death of the patient in a disturbingly large percentage of cases. Also, if the fact that the cervical lymph nodes are the primary locations of metastases, is considered in light of the above, it will cause much of the argument about

whether to include radical neck dissection in the original operative procedure, to disappear.

Investigations are now in progress to determine the hormonal influence on thyroid cancer and some interbalance between the thyroid and pituitary has been established. To prevent the development of the thyroid stimulating hormone (TSH) by the pituitary, it is now considered advisable to keep all patients in a euthyroid state following radical surgery by the administration of desiccated thyroid extract, and never to allow such a patient to fall back into a stage of thyroid deficiency.

THE MONTH IN WASHINGTON

THE OVERRIDING HEALTH ISSUE HERE—and one of the more debated subjects in any field—has been the dispute over radiation health hazards.

Out of the controversy, it is clear, will come a sharply stepped-up federal program of evaluating radiation levels, testing foods, and determining the effects of radiation on the human body.

Already, Arthur S. Flemming, Secretary of Health, Education and Welfare, has called for such an expanded program. And key congressmen are even more insistent that the government do more work in this area.

The growing concern over radiation levels and their effect on health has prompted harsh criticism of the Atomic Energy Commission by some lawmakers who contend the agency is minimizing radiation dangers because it handles the testing of nuclear bombs.

Agency officials claim they have held back no information from the public, but they agree on the need for a government-wide survey of the entire problem to determine how it might best be handled. At present, the AEC does the bulk of the research work on the biological effects of radiation.

The AEC and the Public Health Service have reported that the amounts of radioactive strontium-90—the isotope that is released into the atmosphere by hydrogen bomb shots—have been far below estimated danger levels in food that has been tested.

However, Mr. Flemming has conceded that much more research has to be done. For example, he pointed out, little is known now about how much strontium-90 is retained within the body, though the amount consumed can be gauged.

A special advisory committee of 12 scientists and physicians that was appointed by the Health Service recommended after a year's study an exhaustive program of radiation research and protection as well as shifting prime responsibility from the AEC to the Health Service. The advisory group, headed by Dr. Russell H. Morgan of John Hopkins University, pro-

posed also some sort of federal supervision over X-ray machines used by physicians.

Chairman Lister Hill (D., Ala.) of the Senate Labor and Public Welfare Committee has introduced legislation to carry out the advisory group's recommendations, and called for hearings on the measure.

Meanwhile, the National Academy of Sciences with the backing of the Administration, has undertaken a broad new investigation of the biological effects of radiation.

Notes

The House overwhelmingly approved the Keogh-Simpson measure to encourage retirement plans for the self-employed. Sen. Harry F. Byrd (D., Va.), chairman of the Senate Finance Committee, promptly announced that he would hold hearings on the legislation this session. Last year, the Senate Finance Committee was unable to hold hearings on the measure since it passed the House too late in the session.

Rep. Aime J. Forand (D., R. I.), admitted that the future of his bill to provide government medical and hospital care as part of social security program is dark.

In a report to Congress, the American Medical Association noted "solid progress" in its program to improve the health care of the aged. Dr. Leonard W. Larson, chairman of AMA's Board of Trustees, said in a letter to the House Ways and Means Committee that the development of new insurance programs and expansion of existing lower cost protection for the elderly are moving forward "even faster than many of us would have dared hope only a few months ago."

The Defense Department's handling of the Medicare program providing treatment in civilian hospitals for qualified dependents of military personnel came in for some new congressional criticism. In a report accompanying an emergency money measure, the House Appropriations Committee said it was concerned with the "high costs" and believes "that little or no effort has been made to obtain reasonable rates for fees and expenses."



heart page

PHONOCARDIOGRAPHY

PHONOCARDIOGRAPHY is a graphic method which permits recording of sounds and murmurs originating in the heart and great vessels. O. Frank (1904) was the first to record visually heart sounds and since that time phonocardiography has progressed and is now used routinely. The method is based upon a microphone placed on the chest, accepting vibrations of the heart sounds and transforming them into "electrical waves." Then the output is amplified and recorded on paper. In order to time correctly the sounds and murmurs recorded by the phonocardiograph simultaneous registration of an electrocardiogram, jugular pulse, carotid artery pulse, intracardiac pressures, or other reference record is necessary.

The aim of phonocardiography is not only to record the fugitive auscultatory findings and so to have them valuably documented, but also the phonocardiograph allows the transfer of auscultatory observations into the optical field permitting precise time measurements and demonstrating additional low frequency sounds which are beyond the perception of our ear.

In general, two types of phonocardiographic records are used: stethoscopic and logarithmic. A third method, spectrophonocardiography, is now under study and may give excellent information. With the stethoscopic device all cardiac vibrations are recorded, even if inaudible to the ear, whereas logarithmic phonocardiography represents rather a visual reproduction of our clinical auscultatory findings.

It has helped not only to analyze auscultation of the heart in health and disease, but phonocardiography has also been used to register the fetal heart sounds and in intracardiac studies.

Normally, two heart sounds are present, one at

Herbert H. Schafer, M.D., *Augusta*

the beginning and one at the end of ventricular systole. In addition, during ventricular diastole, two other heart sounds may be recorded known as the third and fourth sounds.

Potain recognized in 1866 the splitting of the second sound during inspiration. Phonocardiography has shown that the earlier component is due to aortic valve closure whereas the second component is due to pulmonary valve closure. The first component of the second sound is the only one to be transmitted toward the apical region. Transmission of the second component toward the apex is only found in pathologic conditions such as septal defects or lesions complicated by pulmonary hypertension. Under such circumstances the physiologic splitting of the second sound has been replaced by abnormally wide splitting. Both complete right bundle branch block and pulmonic stenosis produce a marked delay in pulmonic closure. Phonocardiography has also allowed the study of a paradoxical splitting of the second sound due to prolongation of left ventricular systole.

Phonocardiography has been of great help in clinically difficult situations such as differentiation between low pitched diastolic sounds resembling a diastolic rumble. Another difficulty may represent a systolic snap leading to an erroneous diagnosis of mitral stenosis. Clinically, the systolic snap may be easily mistaken as the second sound and consequently the second sound is considered as an opening snap. The phonocardiogram resolves such difficulty.

As mentioned above, phonocardiography has not only helped in difficult situations but it has also per-

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Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

mitted differentiation of gallop rhythms. Other situations in which phonocardiography is of value are the protodiastolic vibrations confirming pericardial calcifications and the evaluation of the delay of the first heart sound in mitral stenosis. The distance from the opening snap to the first sound has been shown to vary quantitatively with the severity of the mitral stenosis. Not the least of the benefits to be obtained from phonocardiography is its ability to serve as the "referee" or court of last appeal in deciding or settling debates in the clinic, ward, and classroom between students, house officers, and even professors concerning the exact

nature of normal, abnormal, and adventitious heart sounds. As has been true with electrocardiography, the more familiar one becomes with phonocardiography the less the experienced observer or clinician will require its use in evaluating patients. In other words familiarity with the method and careful analysis of the results usually improves one's ability to analyze the clinical phenomena with less use of the apparatus.

The phonocardiograph is therefore used to record, for visual analysis, our auscultatory impressions, to supplement our clinical findings, to inform us of physiological events and their alterations in the cardiac cycle and to referee disputes concerning these several facts.

Doctors Have Long Record of Service in Halls of Congress

AMA Bulletin

THREE HUNDRED AND SIXTY-TWO physicians have served in the U.S. Congress from 1774 to 1959.

At least 14 of the MDs also were state or territorial governors, and three states selected doctors from this group as their first governors.

Five physicians signed the Declaration of Independence.

These and other interesting facts about physicians in Congress appeared in a recent Congressional Record as the extension of remarks by Rep. Ivor D. Fenton, Pennsylvania, one of the six MDs serving in the 86th Congress.

Object of Report: The article, Physicians in Congress, was prepared by Jaroslav Nemec, librarian of the American Medical Association's Washington office.

"If the report does nothing else it will document the point we have been making for years," said Rep. Fenton. "There is nothing new, unusual, or improper in doctors taking an acting part in the national government; they have been doing so from the very beginning of the republic."

States that were members of the original thirteen colonies have sent the most physicians to Congress. Leading the list is Pennsylvania with 52—two are in the present Congress. Next are New York with 48, New Jersey with 30. Ohio, although coming into the Union later, has sent 26 doctors to Washington. Other totals include: Virginia 18, Georgia 17, Maryland 16, New Hampshire 14, Massachusetts 13, Kentucky 12, North Carolina 11, and Missouri 10.

Puerto Rico's present resident commissioner, Dr. A. Fernos-Isern, also is a physician. He is a non-voting member of the House.

Alaska, newest of the 49, kept up the tradition of doctors in politics by sending Ernest Gruening, MD, to the Senate. He also is a former Alaskan governor.

Dr. Josiah Bartlett, a New Hampshire delegate to the Continental Congress, was the second person to sign

the Declaration of Independence. He also was a signer of the Articles of Confederation, a judge, member of the Constitutional Convention, and governor of New Hampshire.

In every Congress: Other physicians who signed the Declaration were Drs. Lyman Hall, Benjamin Rush, Matthew Thornton, and Oliver Wolcott. All except Dr. Wolcott were in active practice at the time.

In the critical years of 1783-84, eleven doctors were in the young Congresses that struggled to keep the states united.

"It is a tribute to the versatility of the profession that in the 181 years since 1775, physicians have sat in every Congress," Nemec wrote.

A total of 167 physicians were Democrats, 69 Republicans. There is no record of party affiliation for 32, and party labels were not attached to the 27 who sat in the Continental Congress between 1775 and 1788. Other MDs in Congress were members of other parties, including Whigs, Federalists, Jacksonian Democrats, and American Party.

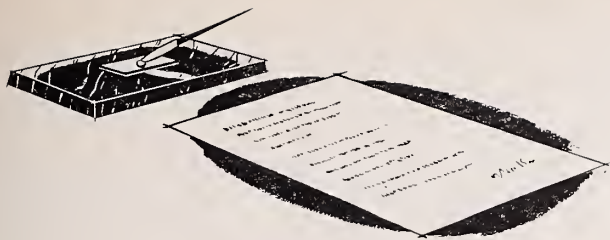
Three hundred and twenty-five served in the House, 37 in the Senate.

During Civil War: During the troubled years from 1810 to 1849—the War of 1812, the struggle for expansion, the Mexican War, the early political skirmishes over slavery—there were at least eight and usually 12 to 18 doctors in Congress.

In the following few sessions—the years leading up to the Civil War—the medical profession also was well represented in Congress. During the war many MDs were with the armies, but between five and seven usually were seated in Washington.

While 362 doctors have reached the U.S. Congress, hundreds of other physicians have served their communities and states as sheriffs, judges, state legislators, state and national committeemen, members of boards of education, and as city and state officials. Thirty-three physicians now are serving in state legislatures.

Savannah Evening Press



abstracts by georgia authors

Alden, Herbert S., M.D.; Weens, H. Stephen, M.D.; and Youmans, Harry D., B.S., 69 Butler Street, Atlanta 3, Georgia, "Observations on Radiation Exposure in Dermatologic X-Ray Therapy," Arch. Dermat. 79:159-171 (Feb) 59.

This paper reports the history and pertinent comments regarding X-radiation exposure in the past, and records some of the experimental evidence at hand showing the quantities of radiation that may occur in the gonads in ordinary dermatologic treatment. The experiments recorded in the paper are in part an answer to the request of the National Academy of Science that more experimental work with X-ray by the practicing physician should be done, and reported to the medical public.

The authors have measured the amount of radiation which occurs at, or near the gonadal areas in patients under treatment for acne, and other routine X-ray treatment for dermatologic conditions, with diagrams illustrating the poor, better, and best methods of protection.

They conclude that it is evident that some X-radiation does reach the gonads in the use of therapeutic X-ray to the skin, but that by direct measurement this quantity is well below reasonable limits of that advised by governmental authorities, and that the genetical hazard of X-ray in routine dermatologic therapy is a hundred to a thousand times less than the genetical hazards of wearing tight clothing, or tight trousers.

They recommended such measures as: (1) The use of cones in all treatments, (2) the consistent and better use of lead shielding to the lower body, (3) the use of lead on, or under the treatment table, and (4) the abandonment of antiquated X-ray machines.

Florence, Thomas J., M.D. and Scott, Charles Jr., M.D., 403 Boulevard, N.E., Atlanta, Georgia, "Transperitoneal Lithotomy and Application to Other Urologic Surgery," J. Urol. 81:97-98 (Jan) 59.

Urological surgery has been usually confined to the extraperitoneal route because most of the urinary structures are outside of the peritoneal cavity and because of the possible danger of spillage of urine into the peritoneal cavity. These are selected cases, however, where the transperitoneal approach is easier and more rapid, definitive work can be done, also surgery on another abdominal viscus could be performed

at the same time. The advantages of the recent antibiotics and proper drainage plus the increased exposure acquired make the abdominal route an inviting one for an increasing number of urologists.

Lineback, Merrill, M.D., 124 W. Princeton Avenue, College Park, Georgia, "Penicillin Resistant Group-A Streptococci in Nose and Throat Infections," Laryngoscope 69:189-193 (Feb) 59.

Over a period of five years routine throat cultures were made and 22 cases of streptococci of Lancefield Group A were found which were the cause of throat disease and were in addition resistant to penicillin. All of the cases had had previous "shots" of penicillin for a "cold" or sore throat and were not responding to still more of the same. Specific sensitivity tests with the serial dilution technique revealed that tetracycline was the most effective antibiotic, with Erythromycin® and chloramphenicol running a close second choice. The desirability of waiting the 48 hours required for the sensitivity test to return is emphasized as it allows the patient time to start developing his own antibodies. To guard against sore tongue and oral moniliasis, the B-complex vitamins and Nystatin® are of value. Rules of value in determining which, when, and how much of an antibiotic should be given are included in the paper. Since not all streptococcal infection are sensitive to penicillin, this drug should be used with caution as its dangers far outweigh its usefulness.

Flesch, W. L., Waycross, Georgia, "Air Disimpaction of Ureteral Calculi," J. Urol. 81:96 (Jan) 59.

A method is presented using a bolus of compressed air via a ureteral catheter and a small syringe to disimpact ureteral calculi. A ureteral catheter is passed to the point of impaction of the calculus. If drainage cannot be established, a 10 cc. syringe with approximately 4 cc. of air is connected to the catheter by means of a rubber irrigating connector. The air is then injected, while observing the orifice through the cystoscope. If the air goes by the stone, there will be a momentary aggravation of pain in the flank, but this is usually followed by a gush of urine, through and around the catheter. Air is advocated because of two unique advantages. First, from the point of safety, it is compressible. It will not

act like a hydraulic piston with straight force, as when one uses water for this purpose. Secondly, air is lighter than water or urine and will tend to go up beyond the stone and into the kidney, if the patient is in a slightly inclined position on the table. It is pointed out that rupture of the ureter by direct force on a ureteral catheter has not been encountered since this method has been in use.

Smith, George W., M.D.; Jack Griffin, M.D.; and Malcolm Sayre, M.D., Medical College of Georgia, Augusta, Georgia, "Treatment of Myasthenia Gravis," South. M.J. 52: 352-356 (March) 59.

The medical treatment of myasthenia gravis has included neostigmine, pyridostigmin (Mestinon®), and more recently ambenonium chloride (mysuran chloride). Numerous other experimental drugs are being used with less favorable results.

The surgical treatment of myasthenia gravis has been limited to thymectomy. More recently denervation of the carotid sinus was introduced by the French in an attempt to improve the course. There were no deaths or sequelae from the denervation and they reported their results in the 13 cases as follows: cured, one case; considerable improvement in three cases; some improvement in four cases; and failure in five cases.

A case is reported treated by bilateral carotid denervation. The patient showed improvement for one year and then died suddenly of the usual respiratory failure. This is the first reported case of such a procedure in this country. There appears, from the foreign reports, that the procedure favorably influences the course, but needs to be viewed critically as myasthenia gravis characteristically has spontaneous remissions and exacerbations. The procedure should be given a thorough and critical trial in a substantial number of patients. The procedure is simple and does not appear harmful even after the lapse of long periods. There is no rationale for this procedure in the absence of information on the pathogenesis of the disease. This procedure may give added physiologic information, not only relative to the disease process but also the homeostasis of the human. Carotid denervation appears to influence the course of myasthenia gravis, for which we have no cure at present.

Continued on page 240

ABSTRACTS / Continued

Lineback, Merrill, M.D., 124 W. Princeton Avenue, College Park, Georgia, "Phenylbutazone as an Adjunct in the Treatment of Acute Otitis Externa and Other Edema of the Ear, Nose, and Throat," *Laryngoscope* 69:96-99 (Jan) 59.

Butazolidin®, because of its non-hormonal nature and marked effect on edema of inflammatory origin, particularly in the head and neck region, has proved a very effective agent along with the usual antibiotic and local measures. In external otitis, especially, its use usually allows more complete examination of the swollen depths of the canal within three days in contrast to a week or more when it is not used. The usual precautions with regard to peptic ulcer tendency, anemia, and allergy should be observed. The dosage for adults is 600 mgm. in divided schedule for one to three days, then dropping down to 300-400 mgm. for another three days. The short duration minimizes possible side effects. It was used in the following disorders: acute thyroiditis, rhinoplasty and septectomy, nasal furunculosis, acute otitis media, and external otitis secondary to otitis media. In one case of otitis media in a diabetic, the drug

of decisive value in hastening healing when the case was mulling along on antibiotics alone.

Lineback, Merrill, M.D., 124 W. Princeton Avenue, College Park, Georgia, "Diagnosis, Pathogenesis and Management of Acute Otitis Media," *J. Indian Med. Profession*, Vol. 5, No. 7:2,334-2,338 and 2,340-2,342 (October) 1958.

The accurate diagnosis and management of otitis media at any age, but specifically that of the infant and child is dependent on many factors, one of most important being the intelligent application of a pathogenetic "blueprint" in the management of the protean and subtle variations of which middle ear disease is capable. Bacteremic seeding of middle ear transudate is the chief factor in infectious otitis media.

Nasopharyngeal hygiene and maintenance of middle ear aeration are found to be keynotes in any program designed to prevent chronicity and hearing impairment.

A well-timed and performed paracentesis and myringotomy is essential and may be repeated as often as indicated without damage to the integrity of the drum or hearing. Active cleans-

ing of the middle ear space with suction and the sterilized middle ear aspirator set is necessary both for identification of organisms and cell studies and also to prevent accumulation of inspissated secretions that interfere with hearing.

Accurate bacteriology with careful reproduction of conditions obtaining in otitis media, namely an anerobic atmosphere, will facilitate identification of organisms, and careful attention to sensitivity testing and specific antimicrobial administration will avert many serious consequences such as sensitization, bacterial resistance, and monilial super-infection.

Careful and sympathetic instruction of parents in simple procedures of aural and nasopharyngeal hygiene will yield benefits with respect to the child's health.

Chronicity results from failure both by the profession to recognize changes in pathogenesis as outlined and to observe proper surgical and bacteriological technique, and also by the parents who fail to bring their child's disease to competent professional help in time.

Widespread dissemination of the concepts developed in this paper will lead to better management of aural disease.

52 Hospitals in State Win Accreditation

FORTY-NINE GENERAL HOSPITALS and three Veterans Administration hospitals in Georgia have been accredited by the Joint Commission on Accreditation of Hospitals.

The commission recently released its annual list. Eight of the hospitals are in Atlanta.

Dr. Kenneth B. Babcock, Commission Director, pointed out that the omission of a hospital from the list did not necessarily mean it has failed to pass an accreditation survey.

The accreditation program is a voluntary one and only those hospitals which request surveys are visited. Therefore, some hospitals not listed may not have requested surveys. Hospitals with less than 25 beds are, with rare exceptions, not eligible for accreditation.

Statistics show that of the 7,000 eligible hospitals over 4,500 have applied for accreditation and of this number about 75 per cent are accredited. Of the total number of hospitals eligible for survey the percentage accredited is 50.7 per cent.

Accreditation of a hospital has been likened by many to "sterling on silver." It is a mark of distinction and earned by high standards of care.

The joint commission is an agency established by five organizations—The American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, and the Canadian Medical Association—to conduct the hospital survey and initiated by The American College of Surgeons in 1919. The commission began operations on Jan. 1, 1953.

VA hospitals in Georgia that are accredited are located in Atlanta, Augusta and Dublin.

Locations of the other accredited hospitals and their names follow:

Albany, Phoebe Putney Memorial Hospital; Americus, Americus and Sumter County Hospital; Athens, Athens General Hospital, Gilbert Memorial Infirmary, Saint Mary's Hospital.

Atlanta, Crawford W. Long Memorial Hospital, Jessie Parker Williams Hospital, Emory University Hospital, Georgia Baptist Hospital, Grady Memorial Hospital, Henrietta Eggleston Hospital for Children, Piedmont Hospital, Saint Joseph's Infirmary; Augusta, Eugene Talmadge Memorial Hospital, St. Joseph's Hospital, University Hospital; Brunswick, Glynn-Brunswick Memorial Hospital; Camilla, Mitchell County Hospital; Carrollton, Tanner Memorial Hospital; Cedartown, Polk General Hospital; Columbus, Saint Francis Hospital, The Medical Center.

Dalton, Hamilton Memorial Hospital; Decatur, Scottish Rite Hospital for Crippled Children; Dublin, Laurens County Hospital; Elberton, Elberton-Elbert County Hospital; Fort Oglethorpe, John L. Hutcheson Memorial Tri-County Hospital; Gainesville, Hall County Hospital; Griffin, Griffin Spalding County Hospital; LaGrange, City-County Hospital; Macon, Macon Hospital.

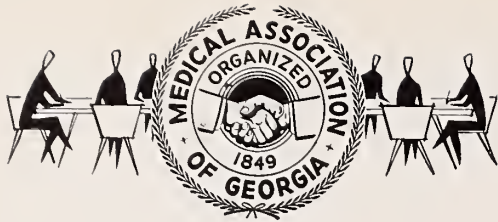
Marietta, Kennestone Hospital; Moultrie, Vereen Memorial Hospital; Rome, Battey State Hospital, Floyd Hospital, McCall Hospital; Savannah, Memorial Hospital of Chatham County, Oglethorpe Sanatorium, Saint Joseph's Hospital, Warren A. Candler Hospital; Sylvania, Screven County Hospital.

Thomaston, Upson County Hospital; Thomasville, John D. Archbold Memorial Hospital; Tifton, Tift County Hospital; Valdosta, Pineview General Hospital; Warm Springs, Georgia Warm Springs Foundation; Waycross, Atlantic Coast Line Railroad Relief Department Hospital, Memorial Hospital; Waynesboro, Burke County Hospital.

Atlanta Journal

NEW MEMBERS OF THE MAG

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Allard, Charles	10 N. Clarendon Road Decatur	Active	DeKalb
Allen, Edwin W., Jr.	1071 S. Wayne Street Milledgeville	Active	Baldwin
Barmore, B. B., Jr.	518 Bellevue Avenue Dublin	Active	Laurens
Beall, Avery P.	P.O. Box 129 Adel	Active	South Georgia
Bloodworth, H. T.	781 Spring Street Macon	Active	Bibb
Bridger, Clarence E.	Phoebe Putney Mem. Hosp. Albany	Active	Dougherty
Clay, Henry T.	577 Walnut Street Macon	Active	Bibb
Cobbs, Beverly W., Jr.	Emory University Clinic Atlanta	Active	Fulton
Darnell, Denville T.	Tate	Active	Cherokee-Pickens
Edwards, Wm. R., Jr.	Lockheed Aircraft Corp. Marietta	Active	Fulton
Gardner, Wm. C.	384 Peachtree Street, N.E. Atlanta	Active	Fulton
Gowder, George D., Jr.	Union County Clinic Blairsville	Active	Hall
Grantham, V. J.	318 Persons Street Ft. Valley	Active	Peach Belt
Griffeth, Joe L.	25 N. Elm Commerce	Active	Jackson-Barrow
Klein, Luella M.	12 Capitol Square Atlanta	Active	Fulton
Little, Charles H.	Union County Clinic Blairsville	Active	Hall
McLain, Ernest K.	VA Hospital Augusta	Active	Richmond
Peace, Robert J.	80 Butler Street, S.E. Atlanta 3	Active	Fulton
Sims, Harry E.	318 Persons Street Ft. Valley	Active	Peach Belt
Smith, W. T.	Talmadge Memorial Hospital Augusta	Active	Richmond
Tailer, Wm. H.	1801 Reynolds Street Brunswick	Active	Glynn
Thompson, John D.	69 Butler Street, S.E. Atlanta	Active	Fulton
Thompson, Josiah	Nicholls	Active	Coffee
Wells, James M.	781 Spring Street Macon	Active	Bibb
Wendorf, Harris S.	205 Mallory Street St. Simons Island	Active	Glynn



the association

DEATHS

JAMES NEWTON BRAWNER, SR., 82, a pioneer Atlanta physician and former president of the Fulton County Medical Society, died March 7.

A psychiatrist with a private practice in Atlanta dating back to 1899, Dr. Brawner was born in Harris County near Chipley. He established the Georgia Pasteur Institute in 1900, and operated it until 1910, when the state took over treatment of cases involving rabies.

Dr. Brawner graduated from the Baltimore College of Physicians and Surgeons, now a part of the University of Maryland. He also took postgraduate work in Europe.

The founder of Brawner's Sanitarium in Smyrna, Dr. Brawner was medical director of the hospital until his retirement in 1955. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, the Southern Medical Association, and the Southern Psychiatric Association. He was president of the Fulton County Medical Society in 1930 and was a member of the Second Ponce de Leon Baptist Church.

He is survived by his wife; two sons, Dr. James N. Brawner, Jr. and Charles M. Brawner of Atlanta; a daughter, Mrs. David E. Miller of Atlanta; a brother, Dr. Albert F. Brawner of Smyrna; seven grandchildren; and five great-grandchildren.

BRADLEY B. DAVIS, 69, of Gainesville died at the Hall County Hospital March 17.

Dr. Davis was born in Newnan, and attended public schools there. He was graduated from the University of Georgia and received a medical degree from Louisville Medical School in 1914. He served his internship in New York City.

He moved to Dallas, Texas, where he became the city's first pediatrician. While practicing in Dallas, he organized the first pediatric clinic there, which is known as the Dallas Baby Sitter today.

Dr. Davis was a veteran of World War I, having served as a captain with the 66th Division Field Hospital Corps in France.

Dr. Davis has served as director of the Chamber of Commerce in Gainesville, was a charter member and president of the Kiwanis Club, and was a member of the board of deacons of the Gainesville First Baptist Church. A member of the Hall County Medical Soci-

ety and the Medical Association of Georgia, Dr. Davis retired from practice in 1955.

Survivors include his wife; his mother, Mrs. Bessie Orr Davis, Newnan; one sister, Mrs. Robert S. Mann, Newnan; two brothers, Willis J. Davis, Atlanta and Theo W. Davis, Newnan.

FRANCIS XAVIER MULHERIN, 74, one of Augusta's best known physicians, died March 14 at his home.

In 1958 Dr. Mulherin was nominated by the Richmond County Medical Society as "Doctor of the Year." Shortly after, he was given the coveted General Practitioner of the Year award, made annually by the Medical Association of Georgia.

Dr. Mulherin was graduated by the Pennsylvania School of Medicine in 1911 and served a four-year internship in Philadelphia Hospital. He served in World War I as a lieutenant colonel with the U. S. Army Medical Corps, 81st Division, as a surgeon.

For a number of years, Dr. Mulherin was a member of the clinical faculty of the Medical College of Georgia and was a staff member of both University Hospital and St. Joseph Hospital.

He was a life member of the Richmond County Medical Society; member of the Medical Association of Georgia, American Medical Association, Alpha Kappa Kappa Medical fraternity, and St. Mary's Catholic Church.

Survivors include his wife; four sons, Frank X. Mulherin, Jr., Tampa, Florida, Dr. Joseph L. Mulherin, Dr. C. Stephen Mulherin, and Richard Mulherin, Augusta; four daughters, Mrs. Polk Land, Columbus, Mrs. Walter Foran, Flemington, N. J., Mrs. Charles Thebaud, Alexandria, Va., and Mrs. Owen Owens, Orenda, Calif; 30 grandchildren; two brothers, Charles P. Mulherin and James B. Mulherin, Augusta; and a number of nieces and nephews.

JOHN BRAXTON WARNELL, 81, who served five terms as mayor of Cairo, died at his home in Cairo March 12.

Dr. Warnell was graduated from the Atlanta College of Physicians and Surgeons in the class of 1900. In addition to serving as Mayor of Cairo, he also served on the City Council. He was an Elder in the Cairo

Presbyterian Church, former member of the state Board of Medical Examiners, former member of the Board of Trustees of Tifton A & M College, now Abraham Baldwin, member of the Grady County Medical Society, the Medical Association of Georgia, and the American Medical Association. He was a Mason, a Shriner, Woodman of the World, and member of the Odd Fellows.

Survivors include his wife; two sons, Willis B. Warnell, Griffin and J. Franklin Warnell, Old Greenwich, Conn.; two granddaughters, Mary Frances Thomas and Ann Camp Thomas, both of Griffin.

SOCIETIES

The CRAWFORD W. LONG MEDICAL SOCIETY unanimously adopted a resolution to back a fund drive for St. Mary's Hospital.

One hundred fifty physicians and surgeons from Albany area counties attended the third annual Southwest Georgia Medical Seminar last month with the DOUGHERTY COUNTY MEDICAL SOCIETY as host.

Physicians from throughout Southeast Georgia and parts of Florida and South Carolina gathered in Savannah recently for a medical symposium on cancer detection and treatment. The symposium was co-sponsored by the GEORGIA MEDICAL SOCIETY and the Chatham County Unit of the American Cancer Society.

Dr. Robert Lee Oliver, who retired as president of the GEORGIA MEDICAL SOCIETY, last January 1, was honored at their annual President's Dinner.

The HART, FRANKLIN, and ELBERT COUNTY MEDICAL SOCIETY met in Elberton with their wives, which consists of the Medical Auxiliary, to discuss plans for Doctor's Day, which was held the latter part of last month.

Members of the MUSCOGEE COUNTY MEDICAL SOCIETY were guests of the medical staff of the Martin Army Hospital recently. Guest speaker was Brig. Gen. Carl Temple from the Surgeon General's Office in Washington, D. C. His subject was "New Trends in the Treatment of Pulmonary Tuberculosis."

The SOUTHWEST GEORGIA MEDICAL SOCIETY met recently in Blakely with Dr. and Mrs. Warren Baxley as hosts. Dr. Robert B. Quattlebaum, a member of the local society and presently serving a residency at Grady Hospital, Atlanta, gave a very interesting talk on "X-ray Assistance in the Differential Diagnosis of the Acute Abdomen."

Physicians from throughout Southwest Georgia and parts of Alabama and Florida gathered in Americus recently for a medical symposium on cancer detection and treatment. This symposium was co-sponsored by the SUMTER COUNTY MEDICAL SOCIETY and the Georgia Division of the American Cancer Society.

The THOMAS-BROOKS COUNTY MEDICAL SOCIETY held their quarterly meeting at the Quitman Country Club. Following supper there was a scientific meet.

Dr. Jack Bowen, Jacksonville, Florida skin specialist, spoke at a recent meeting of the WARE COUNTY MEDICAL SOCIETY. Hosts for the meeting were

Ivey Jacobs, William E. Harden, and H. K. Heath.

Dr. and Mrs. E. L. Harrell entertained the WAYNE COUNTY MEDICAL SOCIETY at dinner recently at the Bon Air Restaurant.

The FIRST DISTRICT MEDICAL SOCIETY met at the Forest Heights Country Club in Statesboro last month. Dr. Lee Howard, Jr. from Savannah, president, was in charge of the program.

The SECOND DISTRICT MEDICAL SOCIETY met at the Methodist Church Recreation Hall in Tifton last month. The scientific session featured talks by Dr. Thomas Findley, Medical College of Georgia; Dr. Henry K. Jarrett, Jr., Tifton; and Dr. Robert E. Fokes, Jr., Moultrie.

The spring meeting of the SIXTH DISTRICT MEDICAL SOCIETY was held at the Monroe County Health Center in Forsyth. The meeting was followed by a bar-b-que supper.

The NINTH DISTRICT MEDICAL SOCIETY held its 1959 Spring Meeting last month in Gainesville. Scientific talks were made by Dr. P. F. Brown, Jr., Gainesville, Dr. Ben Nalley, and Dr. W. D. Stribling all of Gainesville and Dr. Garland Herndon, Emory University.

The TENTH DISTRICT MEDICAL SOCIETY was held in Augusta. The entertainment consisted of golf in the morning followed by a luncheon. The guest speaker was Dr. Edward Rynearson of the Mayo Clinic. He presented a talk on "Hyperinsulinism vs. Functional Hypoglycemia."

ANNOUNCEMENTS

The Post-Graduate Medical School of the New York University-Bellvue Medical Center announces a few openings in graduate courses available during the 1959-1960 academic year. They may be taken as part of a residency program or in preparation for specialty board examinations. Courses in the following fields are offered: anesthesiology, dermatology and syphilology, medicine, orthopedic surgery (January 1960), otorhinolaryngology, radiology, and surgery. Further information may be obtained by writing or phoning the Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, New York 16, New York.

The Woman's Hospital Division of St. Luke's Hospital in New York City offers a one week course in "The Conduct of Labor and Delivery." This is for general practitioners and 30 hours Category I Credit is allowed by the American Academy of General Practice. The course consists of lectures, demonstrations, work in the prenatal and postpartum clinics, and assistance in the delivery room. Enrollment is limited. If interested, please write to Mr. Carl P. Wright, Jr., Director, Woman's Hospital, 141 West 109th Street, New York, New York for prospectus and details. The time of the course is October 8 through October 14, 1959. Enrollment will close on September 15, 1959.

The Trudeau School of Tuberculosis and Other Pulmonary Diseases will hold its Forty-fourth Session from June 8 to June 26, 1959 at Saranac Lake, New York.

Attendance at the Trudeau School carries with it some distinction as well as a thorough review for specialization in pulmonary diseases or for work in public health involving tuberculosis. Approximately half of the time is devoted to tuberculosis and the other half divided between such subjects as silicosis, pulmonary fibrosis, emphysema, fungus infection, sarcoidosis, pneumonias, and intrathoracic tumors. The enrollment is necessarily limited and therefore application should be made early. A few scholarships are available for those who qualify. All inquiries should be addressed to the Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 500, Saranac Lake, New York.

PERSONALS

First District

J. K. TRAIN, JR. was elected president of the Georgia Society of Ophthalmology and Otolaryngology at their annual meeting last month.

GABRIEL d'AMATO, Savannah, was a discussant at the closing session of the second annual psychiatric symposium sponsored by the Bradley Center in Columbus.

Second District

No news submitted.

Third District

HOMER P. WOOD, Ft. Gaines, has been recommended by the grand jury of Clay Superior Court for appointment as a member of the Clay County Board of Education.

JACK McGEE, JOHN DEATON, GUY DILLARD, A. B. CONGER, S. A. RODDENBERRY, and DAVE VARNER all of Columbus attended a medical symposium on cancer detection and treatment held in Americus.

CHARLES R. SMITH and LEONARD T. MAHOLICK of Columbus, took part in the second annual Bradley Center sponsored Psychiatric Symposium held in Columbus recently.

BESSIE MAE BEACH, Columbus, has been named to Who's Who in American Women.

Fourth District

The Woman's Auxiliary to the Spalding County Medical Society had as their guest speaker recently VIRGIL B. WILLIAMS, who gave a realistic description of the operation of the mobile hospital unit for the Griffin area.

ROBERT L. BENNETT, medical director of Georgia Warm Springs Foundation, is one of 24 distinguished physicians and scientists appointed to the two new advisory committees of the National Foundation to counsel the Foundation on March of Dimes allocations.

Fifth District

EDWIN EVANS of Atlanta, president of the Diabetic Association of Atlanta, presented a panel of outstanding doctors in the field of diabetes at a meeting

at the Academy of Medicine. The title of the discussion was "A Well-Controlled Diabetic."

More than 75 physicians attended a three-day post-graduate seminar on congenital heart ailments at the Grady Hospital Auditorium. J. GORDON BARROW was in charge of the seminar.

LESTER RUMBLE of Atlanta, chairman of the Crawford W. Long Memorial Committee, Medical Association of Georgia, was guest speaker at a recent meeting of the Rho Chi honorary pharmaceutical society of the Pharmacy School of the University of Georgia, honoring Dr. Crawford W. Long.

RIVES CHALMERS and THOMAS P. MALONE took part in the second annual psychiatric symposium sponsored by the Bradley Center, Columbus.

ALEXANDER D. LANGMUIR, chief of the Epidemiology Branch of the Communicable Disease Center, U. S. Public Health Service in Atlanta, spoke to members of the Georgia Hospital Association during their meeting at the Bon Air Hotel in Augusta.

A. H. LETTON of Atlanta gave the keynote addresses at recent meetings of the American Cancer Society in Gainesville and Atlanta. Dr. Letton also was recently chosen secretary-elect of the Southeastern Surgical Congress.

B. T. BEASLEY of Atlanta, founder of the Southeastern Surgical Congress, has been installed as president of that group at its 27th annual convention in Miami Beach, Florida.

The Atlanta Radiological Society recently elected W. C. COLES as their president for 1959-1960 and J. L. CLEMENTS, JR. as their secretary.

Sixth District

JAMES JOHNSON, JR. spoke before the Milledgeville Kiwanis Club at their luncheon meeting.

At a recent meeting of the Georgia Psychiatric Association held in Atlanta, JOE COMBES of Milledgeville was elected president of the organization.

Seventh District

WARREN MATTHEWS has been elected president of the Rotary Club of Marietta for the 1959-1960 year.

Eighth District

E. R. JENNINGS of Brunswick told of ways to improve the community from a medical standpoint in an address at a meeting of the Exchange Club.

W. C. SAMS of Ocilla will head the 1959 Irwin County Red Cross Drive.

S. WILLIAM CLARK, JR., Waycross eye specialist, has been certified as a Diplomate of the American Board of Ophthalmology. He has also been accepted by the American Academy of Ophthalmology and Otolaryngology.

Ninth District

TOM BOSWELL, Tate; E. A. ROPER, C. J. ROPER, G. H. PERROW, Jasper; T. J. VANSANT, Woodstock; M. G. HENDRIX, Ball Ground; GRADY COKER, ARTHUR HENDRIX, CHARLIE ANDREWS, B. K. LOOPER, JOHN CAUBLE, WILLIAM H. NICHOLS, and BOB JONES, Canton were honored by the Woman's Auxiliary of the Cherokee-Pickens Medical Society at a Doctor's Day Dinner held at Pine Crest Inn.

A. FREDERICK BLOODWORTH of Gainesville,

Health Education representative from North Georgia for the Georgia Tuberculosis Association, attended a two day meeting of the executive board of the Georgia Trudeau Society in Atlanta.

Recently on "This Is Your Life" T.V. show was JAMES D. SCHULER of Ellijay.

Tenth District

The Augusta Area Tuberculosis Association has installed PRESTON D. ELLINGTON as their president. RUFUS F. PAYNE, superintendent of Eugene Talmadge Memorial Hospital, was guest speaker during the annual meeting of the Augusta Area Tuberculosis Association.

One of the speakers at the ninth annual convention of the Student American Medical Association held in Chicago recently was CORBETT H. THIGPEN of Augusta.

WILLIAM D. JENNINGS, JR. and ENON C. HOPKINS of the Augusta VA Hospital staff have been certified as Diplomates in their respective medical specialties, Jennings by the American Board of Surgeons and Hopkins by the American Board of Internal Medicine.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

EXECUTIVE COMMITTEE OF COUNCIL Chairman George Dillinger called the meeting of the Executive Committee of Council to order at 12:30 P.M. at the King and Prince Hotel, St. Simons Island, March 8, 1959.

Members of the Executive Committee present included Lee Howard, Sr., Savannah, President; Luther H. Wolff, Columbus, President-Elect; Chris J. McLoughlin, Atlanta, Secretary; George R. Dillinger, Thomasville, Chairman of Council; and J. G. McDaniel, Atlanta, Chairman of the Council Finance Committee. Also present was Mr. M. D. Krueger, MAG Executive Secretary.

MAG STANDING COMMITTEE APPOINTMENTS—Chairman Dillinger and the Committee made the following appointments to Standing Committees of the Medical Association of Georgia:

- Cancer Committee:* Hoke Wammock, Augusta, Chairman.
- Crawford W. Long Memorial Committee:* Calvin S. Allen, Jr., Gainesville (1962), replacing A. B. Boyd.
- Constitution and By-Laws:* Schley Gatewood, Americus (1962), replacing William P. Harbin.
- Geriatrics:* Milton F. Bryant, Atlanta, reappointed to serve until 1962.
- History and Vital Statistics:* Morgan Raiford, Atlanta, reappointed to serve until 1962.
- Hospital Relations:* Kirk Shepard, Thomasville, reappointed to serve until 1962; A. W. Simpson, Jr., Washington, reappointed to serve until 1962; Fred Simonton, Chickamauga, reappointed to serve until 1962; P. W. Warga, Athens, reappointed to serve until 1962; John Mauldin, Atlanta (1962), replacing A. B. Conger; and D. Lloyd Wood, Dalton (1962), replacing H. A. Goodwin.
- Industrial Health:* George Connor, Columbus (1962), replacing Allen Collinsworth.
- Insurance and Economics Committee:* Charles S. Jones, Atlanta, reappointed co-chairman to serve until 1962; W. L. Pomeroy, Waycross, reappointed to serve until 1962; H. Holt Hammett, Jr., LaGrange (1962), replacing Luther Wolff; and Walter P. Rhyne, Albany (1962), replacing Rudolph Bell.
- Legislation:* E. A. Allen, Atlanta, reappointed to serve until 1962; Albert M. Deal, Statesboro, reappointed to serve until 1962; and John Bell, Dublin, appointed to serve until 1960.
- Maternal and Infant Welfare:* Eugene Griffin, Atlanta, reappointed to serve until 1962 and A. G. LeRoy, Thomson, reappointed to serve until 1962.
- Medical Defense:* W. Bruce Schaefer, Toccoa, reappointed to serve until 1962.
- Medical Education:* J. Willis Hurst, Atlanta (1962), replacing R. C. McGahee.

- Mental Health:* R. J. Van de Wetering, Atlanta, appointed Chairman; Charles Smith, Columbus (1962), replacing Arthur Knight, Jr.; T. J. Vansant, Jr., Marietta, reappointed to serve until 1962; and Rives Chalmers, Atlanta, reappointed to serve until 1962.
- Professional Conduct:* Lee Howard, Sr., Savannah, replacing W. F. Reavis, with C. F. Holton, Savannah, as Chairman per the Constitution and By-Laws.
- Public Health:* H. J. Bickerstaff, Columbus, reappointed to serve until 1962.
- Public Service:* Albert M. Boozer, Dalton, reappointed to serve until 1962; Simone Brocato, Columbus (1962), replacing Clarence C. Butler; and Alec Jones, Griffin (1962), replacing I. R. Berger.
- Rural Health:* Charles McArthur, Cordele, reappointed to serve until 1962; H. R. Cary, Milledgeville, reappointed to serve until 1962; and Hugh B. Cason, Warrenton, reappointed to serve until 1962.
- Scientific Exhibits Awards:* Hoke Wammock, Augusta, reappointed to serve until 1962.
- Veterans' Affairs:* Lee Howard, Jr., Savannah, appointed as chairman and F. P. Holder, Eastman (1962), replacing C. R. Andrews.
- Woman's Auxiliary Advisory:* Remer Y. Clark, Marietta, appointed to serve until 1962, replacing W. Bruce Schaefer.

SPECIAL COMMITTEE APPOINTMENTS were referred by the Executive Committee of Council to President-elect Luther Wolff.

CHAIRMAN, HEALTH CARE OF THE AGING COMMITTEE—By general agreement, Dr. Zack Cowan was appointed Chairman of this newly formed committee to be set up by the Insurance and Economics Committee and it was recommended that Carl C. Aven be alternate in case Dr. Cowan cannot serve as chairman of this Committee.

DATE AND SITE OF THE NEXT EXECUTIVE COMMITTEE MEETING—By general agreement the next Executive Committee of Council will be held at 10:00 A.M., April 12, 1959 at the Headquarters Office, Atlanta.

There being no further business the meeting was then adjourned.

PUBLIC SERVICE COMMITTEE MEETING

THE PUBLIC SERVICE COMMITTEE of the Medical Association of Georgia met March 11, 1959 at 2:10 P.M. in the MAG offices, Academy of Medicine, Atlanta.

Present were John Heard, Decatur; Albert Boozer, Dalton; I. R. Berger, Athens; and E. P. Inglis, Marietta. Also present were C. Monroe Templeton, Augusta, Chairman of the Public Relations Committee for the MAG Annual Session in Augusta, May 17-20; Mr. Ed Scott, Augusta Newspapers Inc., and Mr. John F. Kiser, MAG Headquarters Office.

Dr. Heard reported on the President and Secretaries Conference held in February in Atlanta and various suggestions and comments were made by members of the committee.

The Committee then discussed in detail the proposed supplement to the Sunday Augusta newspapers to be published May 17 in connection with the Annual Session. Dr. Heard submitted a list of topics for articles to be included in the supplement and committee members made suggestions and comments. Various assignments for these articles were made by the Committee and it was agreed that the Committee would meet again in Augusta on Sunday, April 19.

There being no further business the meeting was adjourned.

WEEKLY HEALTH COLUMN COMMITTEE MEETING

THE MEETING OF THE MAG WEEKLY Health Column Committee was called to order Wednesday, April 8, 1959 at 7:00 P.M. by Chairman H. C. Derrick, Jr., LaFayette.

Present, in addition to Chairman Derrick were: August C. Yochem, Jr., Atlanta; T. J. Vansant, Jr., Marietta; C. J. Wyatt, Jr., Rome; Lamar F. Glass, Atlanta; Mrs. Bob Christian; and Mrs. Emily M. Grinalds of the Headquarters Office Staff.

Chairman Derrick read a letter from the Georgia Tuberculosis Association congratulating the Committee for the fine "Doc Mag" columns during 1958. The letter suggested that tuberculosis be the subject for one or more articles during the year 1959, and the Tuberculosis Association offered to assist in gather-

ing information for the writers of the columns.

The following articles were approved for release:

Fatigue Not Always Due to Overwork
Swelling May Mean Kidney Trouble
Childbirth Is Safer Than Ever
Should You Smoke?

The following articles were read for discussion by the Committee:

Pilodunal Cysts	Glass
Athlete's Foot	Vansant
Epilepsy Is No Disgrace	Yochem
Don't Fertilize the Seeds for Emotional Illness	Yochem
Warts	Derrick
Sprained Ankles	Derrick
Tuberculosis	Inglis
Ear Infections	Inglis
Hysterectomy	Neal
Menopause	Neal
Rectal Bleeding	Glass
Acne	Glass

Dr. Vansant will bring article on "Pink Eye" to next meeting.

New articles to be read and discussed at the next meeting are:

Piles	Glass
Hyperthyroid	Wyatt
Hypothyroid	Vansant
Bronchiectasis	Vansant
Thyroid Nodules	Glass
Chicken Pox	Derrick
Measles	Derrick
Scarlet Fever	Derrick
Puberty	Yochem
Senile Psychosis	Yochem
Stress Incontinence	Neal
Irregular Menstruation	Neal
Why Have a Family Doctor	Inglis
Care of the Ears	Inglis

It was duly voted and seconded that the next meeting of the Weekly Health Column shall be on May 27, 1959 at 7 P.M. at the Headquarters Offices, Academy of Medicine, Atlanta, Georgia.

Mrs. Grinalds was instructed to write and remind the members of the committee of the articles they are to bring to the meeting at least two weeks prior to the meeting. She was further instructed to write a letter of appreciation to Dr. David Hearin, 1017 Doctors' Building, Atlanta, for the article he wrote to be published in the Weekly Health Column. Mr. Kiser was instructed to purchase Merck's Manual, price \$6.75 for the use of Mrs. Christian.

There being no further business, the meeting was adjourned at 9:40 P.M.

EXECUTIVE COMMITTEE OF COUNCIL MEETING MINUTES

EXECUTIVE COMMITTEE OF COUNCIL Chairman George Dillinger called the meeting of the Executive Committee of Council to order at 10:30 A.M. April 12, 1959 in the Headquarters Office, Academy of Medicine, Atlanta, Georgia.

Members of the Executive Committee present included Lee Howard, Sr., Savannah, President; Luther H. Wolff, Columbus, President-Elect; George R. Dillinger, Chairman of Council; and J. G. McDaniel, Atlanta, Chairman of MAG Finance Committee. Also present were Albert Morris, Fairburn, Chairman of MAG Rural Health Committee; Mr. John Moore, General Counsel, and Mr. Milton Krueger, Mr. John Kiser, and Mrs. Emily Grinalds of the Headquarters Office Staff.

REVIEW OF COUNCIL MINUTES MARCH 7-8, 1959 & READING OF EXECUTIVE COMMITTEE OF COUNCIL MINUTES, MARCH 8, 1959—Mr. Krueger read the minutes of the Council meeting of March 7-8, 1959 and they were approved as reviewed. The minutes of the Executive Committee meeting of March 8, 1959 were approved as read with the following correction: "*Chairman, Health Care of the Aging Committee—By general agreement, Dr. Zack Cowan was to be approached about the Chairmanship of this newly formed Committee to be set up by the*

Insurance and Economic Committee, and it was recommended that Carl C. Aven be approached as alternate in the event Dr. Cowan cannot serve as Chairman of this Committee."

POISON CONTROL PROGRAM—Rural Health Committee Chairman, Albert Morris, Fairburn, reported that the Rural Health Committee has been working with the State Department of Public Health in helping get Poison Centers established. He stated that they have ready a brochure for printing and distribution before the MAG Annual Session in Augusta. This brochure is to have an asterisk notation showing approval by the Medical Association of Georgia. On motion (McDaniel-Wolff) it was voted to approve this brochure, with the asterisk showing approval by the MAG. The Executive Committee complimented the Rural Health Committee on its excellent activities.

FINANCE COMMITTEE REPORT—Chairman McDaniel reported on the 1959 Budget for the first three months of the year. This report was approved as read. On motion (Wolff-McDaniel) it was voted that the Headquarters Personnel be allowed unusual travel expenses, when necessary.

INTERNATIONAL MEDICAL RESEARCH—Mr. Krueger read a letter from Senator Hubert H. Humphrey requesting the MAG to provide a list of names of leading physicians in Georgia who could provide expert judgment in answer to the question: "What should the United States Government do to strengthen international collaboration toward the conquest of major killing and crippling diseases—such as cancer, cardiovascular ailments, neurological, mental disorders, and the like?" On motion (McDaniel-Wolff) it was voted that the President and Chairman of Council submit a list of physicians to Senator Humphrey.

SYNDICATED HEALTH COLUMNS—Mr. Krueger read a letter from Frances A. Davis, Lemont, Pennsylvania requesting the opinion of MAG concerning Syndicated Health Columns. After general discussion, it was voted on motion (McDaniel-Wolff) to refer this matter to H. C. Derrick, LaFayette, Chairman of the MAG Weekly Health Column Committee.

MICRO-IDENTIFICATION PLAN—Mr. Krueger explained this plan submitted by J. Laurin and Associates of San Francisco, California. It is a blueprint that insures the effective identification and classification of civilian populations in the event of a major catastrophe should befall our nation, they claim. On motion (Wolff-Howard) it was voted to refer this matter to the MAG Civil Defense Chairman for study.

REHABILITATION—Mr. Krueger read a letter from Dr. F. James Funk, Jr., Atlanta, concerning a state-wide rehabilitation plan as proposed by Dr. F. J. L. Blasingame of AMA. Dr. Funk stated that he would be happy to participate in any such survey work. Mr. Krueger also read a letter from Dr. Robert L. Bennett of the Warm Springs Foundation, who also stated the need for a rehabilitation committee. On motion (Wolff-McDaniel) it was voted that the Executive Committee recommend to Council that a special committee be appointed on rehabilitation at the May 16, 1959 meeting of Council.

WORKMAN'S COMPENSATION—Mr. Krueger reported that Secretary McLoughlin and Dr. T. A. Peterson's Industrial Health Committee had met with the State Board of Workmen's Compensation to explain why MAG is seeking a fee schedule revision. Mr. Krueger stated that he had called the Workman's Compensation Board Chairman asking what their action would be. Mr. Krueger read a letter from Mr. Richard W. Best, Chairman, State Board of Workmen's Compensation, which stated that he had been authorized by the Board to advise MAG that the Board does not feel that an increase in medical fees is warranted at this time. After general discussion, it was duly voted and seconded that Dr. Peterson report to Council on May 16, 1959 with recommendations about this problem.

SPECIAL COMMITTEE APPOINTMENTS—President-Elect Wolff reported that he had made the Special Committee appointments and they are as follows:

American Medical Education Foundation Reappointed:

George T. Nicholson, Cornelia, Chairman
J. Hubert Milford, Hartwell
Ruskin King, Savannah
H. Ansley Seaman, Waycross
W. E. Storey, Columbus
John Ridley, Atlanta

Blood Banks

Reappointed:

Lester Forbes, Atlanta, Chairman
Lee Howard, Jr., Savannah
Walter L. Shepard, Augusta
Hamil Murray, Gainesville
F. H. Thompson, Atlanta

Frank Lewis Beckell, Columbus
Joseph Hertell, Atlanta

Crippled Children

Reappointed:

J. C. Hughston, Columbus, Chairman
F. James Funk, Jr., Atlanta
John L. Chandler, Jr., Augusta
J. W. Bennett, Augusta
W. G. Elliott, Cuthbert

Replacing H. W. Muecke, Waycross—H. M. Coe, Brunswick.

Replacing Robert A. Sears, Atlanta, Robert Mabon, Atlanta.

Replacing W. U. Clary, Savannah, Ruth M. Waring, Savannah.

Replacing Fred E. Murphy, Jr., Thomasville, Atwood M. Freeman, Jr., Albany.

Replacing Charles F. Irwin, Atlanta; Ernest B. Dunlap, Jr., Atlanta.

Eyecare of the Newborn

Reappointed:

J. Jack Stokes, Atlanta, Chairman
Thomas G. McPherson, Atlanta
Joseph L. Girardeau, Atlanta
C. A. N. Rankine, Atlanta
Robert E. Fokes, Jr., Moultrie
(New Member)

Medical Civil Preparedness

Reappointed:

Edgar M. Dunstan, Atlanta, Chairman
Lee Battle, Rome
Perry P. Volpitta, Augusta
T. Fletcher Hanson, Macon
T. J. Ferrell, Waycross
Joseph S. Skobba, Atlanta
Charles E. Dowman, Atlanta
George M. Hutto, Columbus
John L. Elliott, Savannah
Virgil B. Williams, Griffin
George R. Dillinger, Thomasville
(New Member)

Ministerial Liaison

Reappointed:

Needham B. Bateman, Atlanta, Chairman
Avery M. Dimmock, Atlanta
Marion A. Hubert, Athens
Edward Y. Walker, Milledgeville
F. G. Eldridge, Valdosta
Henry H. Boyter, Columbus (New member)

School Child Health

Reappointed:

Grady Black, Griffin, Chairman
Robert N. Poole, Atlanta
M. D. Pittard, Toccoa

Replacing Virginia, McNamara, Atlanta—J. B. Morton, Thomasville

Replacing Maurice F. Arnold, Hawkinsville—William H. Bonner, Athens

Radiologic Safety

Reappointed:

Robert M. Tankesley, Atlanta, Chairman
F. G. Eldridge, Valdosta
Oliver T. Ghent, Gainesville
R. C. Pendergrass, Americus

VFW Liaison

Reappointed:

W. Bruce Schaefer, Toccoa, Chairman
Charles R. Andrews, Canton
Chris J. McLoughlin, Atlanta

Weekly Health Column

Reappointed:

H. C. Derrick, Jr., LaFayette, Chairman
C. J. Wyatt, Jr., Rome
J. Harry Lange, Atlanta
Lamar F. Glass, Atlanta
August S. Yochem, Jr., Atlanta
Jule C. Neal, Jr., Macon
E. P. Inglis, Marietta
T. J. Vansant, Marietta

Dr. Wolff reported that he had written Dr. T. F. Sellers concerning the Radiologic Safety Committee, but had received

no answer to date. It was suggested that a column be presented in the Weekly Health Column of MAG to allay the fears of the public on radiation. It was further suggested that the MAG Committee on Radiologic Safety be advised to start functioning.

GEORGIA HOSPITAL—MEDICAL MEDIATION COUNCIL MAY APPOINTMENTS—Mr. Krueger read a letter from the Georgia Hospital-Medical Mediation Council concerning reappointment of the MAG representatives. Represented on this joint committee are the Georgia Hospital Association; Medical Association of Georgia; Georgia Assn. of Hospital Governing Boards; American College of Surgeons, Georgia Chapter; Georgia Academy of General Practice; Georgia Department of Public Health; and the medical specialties of Radiology, Pathology and Anesthesiology. On motion (Wolff-McDaniel) it was voted to reappoint Milford B. Hatcher, Macon, and Mark S. Dougherty, Atlanta, to serve on the Georgia Hospital-Medical Mediation Council. Dr. Howard asked for approval of the standards for smaller hospitals in Georgia, and he will so report to the House of Delegates that the MAG consider making funds available to the Georgia Hospital-Medical Mediation Council to carry out the program. On motion (Wolff-McDaniel) it was voted to defer action on this matter until the House of Delegates has approved the standards. Mr. Krueger was instructed to write a letter to the Hospital-Medical Mediation Council expressing the sympathetic approval of the Executive Committee to this work.

CITY OF ALBANY FEE SCHEDULE—Mr. Krueger read a letter from T. J. Williams, Director of Finance, City of Albany, Georgia requesting the schedule of surgical benefits as approved and accepted by the Medical Association of Georgia. Mr. Krueger asked the Executive Committee for instructions on how to answer this letter, and he was instructed to state that there is no existing fee schedule as he has in the past. This action was taken by consent.

SUNDAY MEETING PROBLEM—Mr. Krueger read a letter from Dr. Lester Harbin, Rome, Georgia suggesting that the Medical Association of Georgia transact all business on some day other than Sunday. Mr. Krueger was instructed to write Dr. Harbin that the Committee has given this matter serious consideration and he was instructed to cite the action of the House of Delegates on this matter.

HEALTH CARE OF THE AGING—Mr. Krueger read the minutes of the Insurance and Economics Committee meeting of March 22, 1959 concerning the Health Care of the Aging. He discussed the problem of securing a chairman for the newly formed committee on Health Care of the Aging. Discussion ensued on this problem and Dr. McDaniel was instructed to approach Dr. John S. Atwater, Atlanta concerning the Chairmanship of this Committee. Mr. Krueger read a letter from Howard I. Wells, Jr., Executive Secretary to the Joint Council to Improve the Health Care of the Aged, inviting MAG to participate in the First National Conference of the Joint Council to Improve the Health Care of the Aged on Friday, Saturday and Sunday, June 12 through 14, 1959. This letter was received for information at this time.

Mr. Krueger presented a letter from the Georgia Hospital Association concerning the formation of a joint council in Georgia on Health Care of the Aging. Mr. Krueger was instructed to write the Georgia Hospital Association that MAG is interested in forming a Joint Council; that the problem is now being worked on; but before proceeding, it must be presented to the full Council for approval; and that recommendations must be deferred until a chairman is appointed.

BUILDING COMMITTEE—J. G. McDaniel reported on recent negotiations concerning the Gulf Life Building. On motion duly made by Luther H. Wolff and seconded by J. G. McDaniel, it was unanimously received as follows:

"The Executive Committee of Council finds the Gulf Life Insurance Building at 938 Peachtree Street, N.E., Atlanta, Georgia suitable to the purposes of the Medical Association of Georgia for use as a headquarters office building and other purposes; the President of MAG is hereby authorized and empowered to execute on behalf of MAG a sales contract for the purchase of said building in the form submitted to this meeting by Counsel with the changes in Exhibit "B" attached thereto with respect to full privileges of prepayment without penalty, return of earnest money and non-payment of Broker's commission in the event the House of Delegates fails to approve said sales contract, all as discussed at this meeting; Executive Committee of Council hereby calls a special meeting of Council to be held immediately after execution of said sales contract by Gulf Life Insurance Company,

said called meeting of Council to consider calling a special meeting in Atlanta of the House of Delegates to view the premises of said building and to determine whether to approve the purchase of said building."

MILLEDGEVILLE REPORT—General Counsel John Moore gave a progress report on the MAG Committee investigating conditions at Milledgeville State Hospital. On motion duly made and seconded it was voted that Council consider this report when completed and the final report be referred to the House of Delegates by Council.

POST-CONVENTION CRUISE—Mr. Kiser read a letter from the United States Travel Agency, Inc., outlining various cruises proposed for the MAG. On motion (Wolff-Howard) it was voted to refer this matter to Henry Tift, Chairman of MAG Convention Committee of Annual Session.

INSURANCE FORM LETTER—Mr. Krueger read a letter from Dr. J. P. Hoover, Rossville, Ga. complaining about the new simplified Standardized Medical & Surgical Insurance Claim Forms. It was duly voted and seconded to refer this matter to the Insurance and Economics Committee with a carbon copy to Dr. Joseph Mercer, Brunswick.

GEORGIA PLAN APPROVAL—Mr. Krueger read a letter from Alan W. Sturm, Supervisor of Group Productions, National Casualty Company concerning approval of their policy for

underwriting the Georgia Plan. Mr. John Dunaway had been paid \$25.00 for policy examination fee, Mr. Krueger stated. On motion duly voted and seconded, it was voted to send this matter to Mr. Dunaway for final approval.

HEADQUARTERS OFFICE REPORT—Mr. Krueger brought to the attention of the Committee certain equipment needed in the headquarters Offices. On motion (Wolff-McDaniel) it was voted to purchase an electric typewriter, an addressograph drawer, a mail scale and an adding machine. The matter of purchase of a new check writer must be brought before Council and any further purchases will have to be presented to Council.

UNFINISHED BUSINESS—It was unanimously voted to send a wire to Secretary Chris J. McLoughlin at the Methodist Hospital, Rochester, Minn. saying how greatly he was missed at the meeting of the Executive Committee and it was voted that flowers be sent him there.

President-Elect Wolff stated that he thought Council should reconsider their recommendations on Social Security for Physicians. It was duly voted and seconded that the Executive Committee request Council's reconsideration of Social Security for physicians and this item be placed on the Council agenda for May 16, 1959.

NEW BUSINESS—The problem of disbursement of funds during the absence of Chris J. McLoughlin was discussed. On motion (Wolff-McDaniel) it was voted that Virgil Williams, Griffin be designated the Officer of the Association to sign checks with J. G. McDaniel if an emergency arises in the absence of the Secretary-Treasurer. The President of the Association is to inform the bank of this change, if necessary.

There being no further business the meeting was adjourned at 2:05 P.M.

Rural Communities Must Solve Own Problems

THE NEED FOR INDIVIDUAL communities to solve their own rural health problems—whether they be those of the aging population or the lack of physicians—was outlined by 24 speakers at the recent 14th National Conference on Rural Health, sponsored by the American Medical Association.

The current trend toward socialized health care cannot be reversed merely by preaching against it, according to Earl L. Butz, Ph.D., dean of agriculture at Purdue University, LaFayette, Ind.

"Aggressive community participation in positive action programs is the best answer to the philosophy held by some people that 'Washington will take care of my social security and welfare,'" he said.

Private enterprise and private initiative must be kept as the "senior partner" in local activities and government, Dr. Butz said, adding that if those services a community decides it must have are not provided by local people and local organizations, they will be provided by the government.

"We must be ever vigilant that our local communities assume the responsibilities put upon them by our private enterprise system," he concluded.

Examples of local enterprise were presented by J. D. Smerchek of the Kansas Farm Bureau, Manhattan, and Roy Battles, assistant to the master of the National Grange, Washington, D. C. Both groups have active rural health programs in which rural persons are—in

the words of the A.M.A. Council on Rural Health—helped to help themselves to better health.

One area in which communities can—and must—help themselves is that of meeting the problems of the aging population, according to Aubrey D. Gates, director of the A.M.A. Division of Field Services. Each community has the resources, the courage and the determination to meet the problems of this group.

The first step in meeting the needs of the aging is an inventory of community assets in the form of its elder citizens—their number, their problems, and their experiences that can be used by the community. Then their needs must be measured and decisions made about how and what is necessary to meet them.

Gates pointed out that many steps are being taken to help communities meet the needs of their aged citizens. These include requests by the A.M.A. that the Congress make available funds to help in the construction of community nursing homes; plans and suggestions offered for building and maintaining safer, more modern facilities; plans for visiting nurse service; suggestions for better home care, and plans for more adequate insurance for the aged.

He urged churches and other organized community groups to help in developing programs for the aged. State committees of doctors interested in rural health and aging may be contacted for help and advice.

Geriatric Health Insurance

SURGICAL, MEDICAL, HOSPITAL, and nursing home care insurance for persons 65 and over has been announced by Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society.

The insurance was offered statewide recently. It will be known as the "Century Plan." Anyone 65 years of age or older may enroll.

Protection for those who enroll will be effective immediately, except for conditions for which treatment has been received during the past year. Benefits for such conditions will be available after a nine month waiting period.

Dr. E. M. Dessloch, Chairman of the Commission on Medical Care Plans of the State Medical Society, described the "Century Plan" as a "bold, pioneer achievement in providing the elderly with the same broad benefits ordinarily offered only to groups of younger persons."

Monthly premiums for the plan will be set at \$9.00 per person.

Physicians' services will be paid according to a fee schedule for: (1) surgery wherever performed; (2) medical care while a bed patient is in a hospital for the first 60 days of confinement; (3) anesthesia and diagnostic X-ray when associated with surgery; and (4)

radiation therapy for the treatment of proven malignancies.

Hospital benefits are provided for the first 60 days of each confinement. During this period the "Century Plan" will provide up to \$10.00 per day for room and board expense and 100 per cent of miscellaneous hospital expenses required for the care of the patient.

Nursing home benefits are available within the same 60 day period, but only when the patient is transferred directly from a hospital to a nursing home. In such case, the "Century Plan" provides up to \$10.00 per day for room and board charges of the nursing home.

Hospital and nursing home benefits are limited to a total of 60 days per confinement. However, if there is a gap of 60 days between the date of discharge from a hospital or nursing home and the date of the next admission to a hospital, a new 60 day benefit is available.

Out patient hospital benefits are payable for the first visit because of surgery or within 48 hours of injury.

The 2,800 physicians who participate in WPS-Blue Shield will accept the surgical-medical benefits paid by the "Century Plan" as full payment of their charges when the policyholder's annual income is under \$2,000 as a single person or \$3,600 as man and wife.

Only standard exclusions will apply such as cases involving war, workmen's compensation, and eye glasses.

Centennial Year for Medical Services

IN 1961 WILL BE THE centennial year of the formation of the medical services, both of the Confederate and Union Forces. The Atlanta Historical Society and the Civil War Roundtable, have been given funds to establish an exhibit on medical services of the Confederate Armies for the centennial period. They have been asked to collect as much informative data regarding this era of medicine as possible, then they may have a medical

exhibit and program that will be interesting, both to professional and non-professional groups.

Any members of the Medical Association of Georgia who can supply information or data regarding the material desired by the Historical Society and Civil War Roundtable would be greatly appreciated. Communications should be addressed to: Dr. Morgan B. Raiford, 679 Juniper Street, N.E., Atlanta 8, Georgia.

Resolution on the Death of Daniel Collier Elkin

Whereas, it has pleased the Beneficent Ruler of the Universe to remove from our midst our friend and fellow member, Daniel Collier Elkin; and

Whereas, Doctor Elkin exemplified all that is good in medical practice, medical research, medical teaching, and true Americanism; and

Whereas, Doctor Elkin by his kindly manner, gracious disposition, and by his wise and constructive counsel endeared himself to us not only as a deliberative body but to each of us as individuals;

Therefore, be it resolved by the Greenbrier Clinic

Advisory Council that we express our sincere sorrow at Doctor Elkin's untimely passing, and that we pay tribute to his memory as a man, as a surgeon, as a teacher of medicine, and as a constructive American; and

Be it further resolved that a copy of these resolutions be spread upon our minutes, a copy be sent to the bereaved family, and a copy to each, *The Journal of the Kentucky State Medical Association*; to *The Journal of The Medical Association of Georgia*, and to *The West Virginia Medical Journal*.

Atlantic City Began as a Physician's Dream

WHEN SOME 15,000 PHYSICIANS converge on Atlantic City in June for the American Medical Association's annual meeting, they will be arriving at a place that began as a doctor's dream of a health resort.

In 1852, when Atlantic City was called Absecon Beach, Dr. Jonathan Pitney, who had a thriving practice in the community of Absecon, saw the advantages of the beach as a health resort. At the same time, a glass manufacturer wanted a railroad to carry his wares. Between them, the two men sold businessmen in the

area on the advantages of a railroad to the island.

Once the railroad was built, a real estate boom occurred. Hotels were built, the town's name changed to Atlantic City, and the "world's leading seashore resort" began.

Atlantic City is a place where one can catch a 600-pound marlin, relax to the gentle motion of the famed "boardwalk carts" or eat all the salt water taffy he wants. In fact, some 50,000 pounds of salt water taffy are sold every summer day on the Boardwalk.

Nation's Family MDs Get Confidence Vote

THE AMERICAN ACADEMY OF GENERAL PRACTICE hired pollsters to ascertain what the public thinks of its family doctors. The results of a pilot study must have surpassed their happiest hopes.

Eighty-one per cent of those questioned had never had a bad experience with a doctor, 73 per cent had no criticism of any kind. Overwhelming was the opinion that their doctors are personally interested in them, clear in explaining illness and unrushed in examinations. It wasn't unanimous, but the critical percentages were small.

The family doctor has long occupied a place of reverent affection in the American tradition. He became a symbol of devotion to duty, a refuge in time of trouble,

valued for his counsel in matters far beyond the reach of medicine.

Periodic reports that he was disappearing, in the widening trend toward specialization, have occasioned public anxiety. But the Academy of General Practice is described as the fastest growing of the many U.S. medical societies.

The family doctor's role is a challenging one. If he is to keep pace with the rapid expansion of medical knowledge, he must have time and energy enough to learn while he heals.

In this effort he can be sustained by the knowledge that his patients appreciate him.

Athens Banner-Herald

1959 CALENDAR OF MEETINGS

State

- Sept. 11-12—Georgia Heart Association, Savannah.
- Sept. 18-19—Georgia Tuberculosis Association, Athens.
- Sept. 18-19—Georgia Trudeau Society, Athens.
- Sept. 20—Georgia Psychiatric Association.
- Sept. 24-26—Georgia Chapter, American College of Surgeons, Sea Island.
- Oct. 9-10—Grady Hospital Clinical Society, Atlanta.

Regional

- May 15-16—Fifth Annual Surgery, Radiology, Pathology Symposium, Oklahoma City, Okla.
- July 22-23—Rocky Mountain Cancer Conference, Denver, Colo.
- Sept. 28-29—Tennessee Valley Medical Assembly, Chattanooga, Tenn.
- Nov. 16-19—Southern Medical Association, Atlanta.

National

- May 25-29—American College of Cardiology, Philadelphia, Penn.
- May 25-29—National Tuberculosis Association, Chicago, Ill.

- May 25-29—American Trudeau Society, Chicago, Ill.
- June 3-7—American College of Chest Physicians, Atlantic City, N. J.
- June 6—Seventh Annual National Medical Civil Defense Conference, Atlantic City, N. J.
- June 5-7—Medical Society Executives Association, Atlantic City, N. J.
- June 8-12—American Medical Association, Atlantic City, N. J.
- July 6-10—Symposium for General Practitioners on Tuberculosis, Saranac Lake, N. Y.
- Aug. 30—American Congress of Physical Medicine and Rehabilitation, Minneapolis, Minn.
- Sept. 27 - Oct. 2—American College of Surgeons, Atlantic City, N. J.
- Sept. 14-17—International College of Surgeons, Chicago, Ill.
- Oct. 3-8—American Academy of Pediatrics, Chicago, Ill.
- Oct. 23-25—American Heart Association, Philadelphia, Penn.
- Nov. 29-Dec. 2—National Society for Crippled Children and Adults, Chicago, Ill.

Foreign Physicians Stretch ECFMC Facilities

THE NUMBER OF FOREIGN trained physicians taking the qualifying examination of the Education Council for Foreign Medical Graduates is rapidly increasing.

Only 298 took the first examination in March 1958; 844 in September 1958; 1,772 in February 1959, and more than a thousand have already registered for the next examination September 22, 1959.

The council, with offices in Evanston, Ill., aids graduates of foreign medical schools in establishing their qualification to assume internships or residencies in United States hospitals.

According to Dr. Dean F. Smiley, executive director of the council, the number of centers where foreign medical graduates can take the examination overseas has greatly increased.

There were no foreign centers for the first examination; 30 for the second, and 44 for the third.

For the next examination there will be 15 centers in Latin America, 14 in the Far East, 7 in the Near and Middle East, 13 in Europe, and 1 in Africa. In addition, examinations are held at various places in the United States.

Doctors to See Army Mass Casualty Care Training

MILITARY AND MEDICAL PREPAREDNESS for the management and care of mass casualties in case of war will feature the seventh annual National Civil Defense Conference which will be held in Atlantic City on Saturday, June 6, immediately prior to the opening of the annual American Medical Association convention.

"The one-day program will highlight medical problems involved in nuclear warfare," said Dr. Harold C.

Lueth, Evanston, Ill., chairman of the A.M.A. Committee on Disaster Medical Care. "The program, unique since it will be presented entirely by the Army Medical Service, will dramatize the important fact that the medical and health professions can take positive action to minimize the impact of mass casualties if properly trained and organized," Dr. Lueth said.

Group Insurance for MAG

YOUR MEDICAL ASSOCIATION, in an effort to provide realistic benefits at low rates, has three Group programs for its membership. The Association was especially cognizant of the need for protection for those members who could not purchase insurance individually. In 1951, a Group Accident and Sickness contract was installed. In 1954, a Group Life program was instituted and in 1958 a Catastrophic Hospital-Nurse insurance program was extended to the members.

Each of these Group programs was first installed without regard to the physical condition of the eligible member. The insurance carrier requested no medical information. Further, the contract with the Insurance Company provides that new members of the Association who apply for the Group coverage within 60 days of

their membership may also obtain benefits without having to answer physical questions.

These programs represent a very valuable protection to our membership, one which we feel should be protected. The best way to accomplish this is by keeping participation of our membership in the Association programs at the highest possible level.

If you are not familiar with or insured under either or all of these plans, contact your Association office. We will be delighted to send you information about the programs. There are letters on file from members who have had occasion to claim under the Disability or Catastrophic programs telling of the valuable assistance these programs furnished in time of need.

Health Insurance Payments

BENEFIT PAYMENT BY INSURANCE companies to the people of Georgia who are covered by health insurance policies reached a new high during 1958, the Health Insurance Institute reported recently.

In the period from January 1 through December 31, 1958, said the Institute, an estimated \$53.9 mil-

lion was paid out to help cover the cost of hospital and doctor bills, and to replace income lost through sickness or disability. This represents a 14.5 per cent gain over the 1957 figure of \$47.1 million, and is based upon reports from insurance companies doing business in the state.

THE GEORGIA INTER-AGENCY TB COMMITTEE

THE GEORGIA INTER-AGENCY TB COMMITTEE was founded in June, 1957 by a group of Georgia citizens interested in improving the over-all management of the tuberculous patient. The committee consists of two representatives from each of 13 agencies. It meets approximately six times each year. Each agency has a one-year and a two-year member on the committee. A new member is appointed by each agency annually to replace the expired term of the one-year representative. The secretarial responsibility of the committee is performed by the GTA.

The committee has representatives from the following agencies:

- Georgia Department of Public Education
- Emory University School of Medicine
- Georgia Department of Public Health
- Georgia Hospital Association
- Georgia League For Nursing
- Medical College of Georgia
- Medical Association of Georgia
- Georgia Board of Examiners of Nurses for Georgia
- Georgia State Nurses Association
- Georgia Tuberculosis Association
- Veterans Administration
- Georgia Veterinary Medical Association
- Georgia Department of Public Welfare

Drs. Carl C. Aven and Walter H. Dunbar are MAG representatives to the Committee. Dr. Dunbar was 1958 chairman. Mr. George Sumerau of Augusta is

the present chairman.

The purpose of the committee is to eliminate overlapping and duplication of services and activities of member agencies. The group is not primarily an action group, but it functions in an advisory capacity. The problems that arise in the handling of TB are discussed at the committee meetings and possible solutions to the problems are reviewed. The educational impact on the committee members themselves by this exchange of information is invaluable and leads to smoother coordination of the agencies themselves.

Problems that have been tackled by the group include that of the tuberculous patients who leave Battey State Hospital against medical advice, the timing of vocational rehabilitation during the patient's convalescence, the use of the tuberculin skin test in mass surveys, the granting of welfare assistance to TB patients and their dependent families, and other subjects.

One of the initial discussions centered around the timing of rehabilitation to patients. A direct result of the committee's discussion of the program was placement of a full-time rehabilitation counselor at Battey State Hospital. Another achievement resulted from a discussion of welfare benefits. Coordination between the local health departments and state welfare department was improved; the decision as to degree of disability and as to payment of welfare benefits of the patient was thereafter handled more expediently.

*Walter S. Dunbar, M.D.
Chairman*

ANNUAL SCIENTIFIC SESSION OF THE AHA

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FRONT COVER



The M.A.G. Milledgeville Study Committee presents report to the Governor. Seated, Governor S. Ernest Vandiver; standing, left, John A. Bell, Jr., Dublin; W. Bruce Schaefer, Toccoa; Corbett H. Thigpen, Augusta; Lee Howard, Sr., M.A.G. President, Savannah; Rives Chalmers, Atlanta; and R. Hugh Wood, Atlanta. (Picture by Jerry W. Huff, *Atlanta Journal-Constitution*.)

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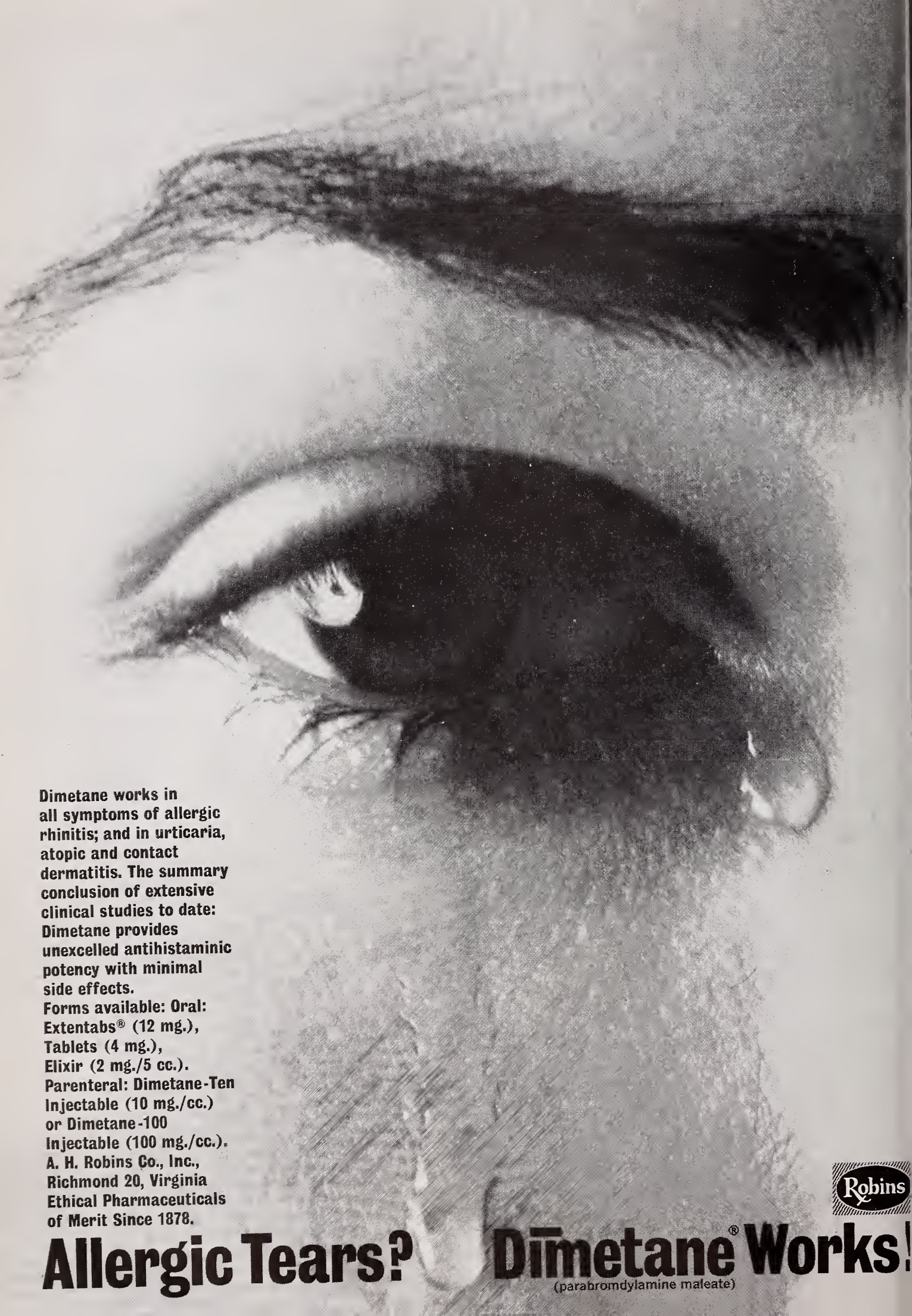
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THE GENERAL PRACTITIONER AND MENTAL HEALTH

The general practitioner constitutes the first line of defense in the fight against mental illness.

Francis M. Parks, M.D., *Carrollton*

MUCH IS BEING WRITTEN today about the problems of mental health, and the role of the general practitioner in coping with these problems. The only reason I have the audacity to contribute another paper to this prolific field is that, it seems to me, much of the material now in print has been written by psychiatrists in a language not comprehensible or appealing to the general practitioner; indeed, much of it may tend to frighten him away from the field. I shall attempt to talk the general practitioner's own language in urging more deliberate and enthusiastic inclusion of psychiatry in our practice. In this discussion we shall be concerned only with minor mental illness and its management by the general practitioner; the psychoses and many of the deep-seated neuroses we will continue to refer. But, as in other fields of medicine, a considerable majority of mentally ill persons can be adequately handled by any general practitioner who is willing to learn a few basic principles of psychotherapy.

Let us approach this subject through three main viewpoints: first, to recognize the urgent importance of mental and emotional problems; second, to understand that if anything is to be done medically to cope with these problems, it is largely up to the family physician to do it; and finally, to consider some of the means available to the physician in working with the mentally disturbed. A case report

is included to illustrate some of the points brought out.

Various studies have indicated the high incidence of psychosomatic illness. From 50 per cent to 60 per cent of the patients coming to the average practitioner have primarily psychogenic problems. The fabulous growth of the tranquilizer industry testifies eloquently on this point. Yet, our usual reaction to these unfortunate people is to assure them, "It is just your nerves . . . you will have to quit worrying . . . just get your nerves under control and you will be all right." Then, as we hand out a prescription for a sedative or tranquilizer, we say to ourselves, "I wish I could have some *sick* patients."

Thus we demonstrate our failure to grasp the fundamentals of the situation, for a little reflection will show that no one is *so* sick as one who is *mentally* sick. We all know people with severe physical handicaps who have found a means to be useful members of society and to lead serenely happy lives. There are numerous patients with chronic heart disease, or bronchial asthma, or diabetes, who give a good account of themselves in the business and social world in spite of their organic illness. Most of us have even known patients dying of cancer who continued to be happy—and to keep their family and friends happy—right up to the time of their death. The only requirement in any of these situations is a well adjusted, mature personality which is willing to accept and live within the limitations imposed by somatic illness. On the other

Presented at the *105th Annual Session of the Medical Association of Georgia, May 18, 1959, Augusta, Georgia.

hand, we see daily numerous people who are dismal failures, with never a well moment, in spite of essentially perfect physical health. We may deduce from the foregoing that a person can feel and perform well if his emotional adjustment is good, regardless of the state of his physical health* and that the most perfect bodily health can in no way ameliorate the unhappiness and suffering of one who is emotionally immature or maladjusted.

It is during the earliest years of life—usually before age five—that the most important personality traits are laid down. The child who is reared to age five by insecure, unstable parents will almost certainly be insecure and unstable himself, however his environment may improve during later childhood. It is also true, in general, that the younger neurotic patients are more amenable to psychotherapy than are their elders. Thus, if we are to do anything to overcome the ever increasing problem of neurosis, we must direct our efforts to the younger generation, to help them before they make their children neurotic, too!

If you believe that I am speaking primarily of the problems of the specialist in psychiatry, I should at this point like to help you change your mind. The average busy family physician probably sees from two to five or more patients each day who could benefit from formal psychotherapy. The psychiatrist usually can serve no more than 10 to 25 patients a week, and many of these patients must continue under therapy for many weeks. It should be obvious that there simply are not enough psychiatrists—nor can there be in the foreseeable future—to meet the enormous need. In addition, many of us practice in areas where psychiatrists are not readily available. Even in the larger cities, matters of prejudice and economics will deter most patients from accepting specialist psychiatric care. If anything is to be done to help these unfortunate victims of “minor” mental illness, you and I, the family physicians, must do it. Only if we all become willing to work at this problem is there any remote chance to check the rising tide of mental illness.

Formal psychotherapy is usually the only means of being of lasting help in chronic psychosomatic illnesses. It is the burden of this paper that psychotherapy can be and needs to be within the realm of the general practitioner. One should not, of course, undertake the practice of psychotherapy without a basic understanding of psychodynamics. Most of our medical schools are now giving undergraduate training in psychodynamics, and the number of postgraduate courses available is increasing. The Ameri-

can Psychiatric Association, in cooperation with the American Academy of General Practice, has initiated a General Practitioner Education Project, under the direction of Dr. Charles E. Goshen of Washington, D. C.

Many psychotherapeutic methods are available to the general practitioner in his efforts to help his neurotic patients; the physician will evaluate each patient as an individual, and will use those therapeutic measures best suited to the particular patient, in the hands of the particular physician. I have listed here several of the methods which have proved useful in my own practice, and in succeeding paragraphs will briefly discuss these methods.

1. The history and physical examination
2. Reassurance
3. Mental catharsis
4. Persuasion
5. Guidance and re-education
6. Psychosomatic palliative treatment

History and Physical Examination

In taking the history, clinical judgment frequently will allow one very early to make a shrewd guess as to whether the patient's illness is primarily psychogenic. If this opinion is reached, it is important to make both history taking and the physical examination unusually thorough, not only to reassure the physician of the correctness of his opinion but (therapeutically) to convince the patient that he has been adequately studied and that the physician speaks with authority in explaining the diagnosis. Indicated laboratory work should also be done, including special procedures done primarily to reassure the patient.

Reassurance

Many patients, whose psychosomatic illness is of recent origin and who have previously been in essentially normal emotional adjustment, will require no more treatment than the physician's reassurance that organic disease is not present. In such cases if the physician can also lead his patient to see the definite relationship between psychically stressful situation and the development of his illness, a prompt cure will almost certainly ensue.

Mental Catharsis

Mental catharsis as used by the general practitioner simply means encouraging the patient to talk about his emotional problems. All that is necessary is time and a willingness to listen. Most neurotic patients will welcome the chance to talk to an interested audience. We obviously are not speaking here of catharsis of deeply repressed material, which, if needed, will usually be left to those with more specialized training. The vast majority of patients will do well without such deep catharsis, however.

*Certain acute illnesses will have to be excepted.

Persuasion

Persuasion has a rather limited usefulness. If the patient's problem is chiefly circumstantial and of recent origin, the solution may be so obvious that the physician has only to persuade the patient to adopt this solution. Unless the physician is adequately trained in counseling in the field involved—vocational, marital relations, etc.—he had best use this method with great caution.

Guidance and Re-education

In guidance and re-education, the physician may accomplish the same ends sought in persuasion without the dangers involved, simply because he leads the patient to make his own decisions. The physician serves as a sort of referee while the patient works through his own economic, social, and emotional chaos; the patient is encouraged when his thinking leads to a sounder method of handling his difficulties, but at all points the patient is made to feel the decisions are his.

Psychosomatic Palliative Treatment

Many patients' illnesses are simply not amenable to psychotherapy as a curative measure. For these, and for those who are in need of deep psychotherapy but who refuse to see a specialist in psychiatry, the physician must use a psychosomatically oriented palliative therapy. This consists chiefly of reassurance in regard to organic illness, understandingly and patiently given, and given over and over again as often as needed, together with the judicious use of drugs, physiotherapy, etc. At all times, in this type therapy, the physician must be careful to retain a firm control of the situation, especially with regard to the patient's demands for habituating or addicting drugs.

A technique which I have found extremely useful in applying many of the above methods is the use of hypnosis. Some have cautioned that the use of hypnosis by the family physician is dangerous. The dangers, however, have probably been over-emphasized. If one bears in mind that hypnosis is not a treatment in itself, but merely a convenient means by which ordinary methods of psychotherapy are carried out, and if one observes a few easily learned precautions, hypnosis is certainly no more dangerous than other modalities of treatment commonly used by all physicians. It is further reassuring that both the British Medical Association and the American Medical Association have officially recognized hypnosis as a proper therapeutic technique.

Case Report

The following case report is presented because, as noted above, it serves to emphasize some of the things which have been discussed.

L.W., 29-year-old white female, married, para iv. For two years she has been subject to spells of crying, unhappiness, and worry over the fact that her husband had a brief and very trivial "affair" with another woman. The husband had always previously been a "model husband." Technical adultery was not committed; the husband has given up his "girl friend," and has resignedly "taken his punishment" for two years. He has thoroughly and repeatedly apologized for his misbehavior. In spite of all this, the patient is unable to forgive him. She will not consider leaving him, however, because she "loves him and her children too much." She therefore makes life unbearable for husband and children by continuous crying and nagging. Sexual adjustment in marriage always has been—and still is—satisfactory to both partners. Patient states her childhood was rather unhappy, but denies serious emotional upset at any time prior to the present illness.

Family History: Patient's mother and two of her children are known to me to be severely neurotic. Patient has one sibling, a younger sister, who is also neurotic but less so than the patient.

Course of Therapy: Patient was brought gradually to realize that her difficulties were a response to her own guilt feelings; that her guilt feelings did not result from wrongdoing on her part but from psychically traumatic treatment she received at the hands of her parents; and that because of her guilt feelings she was inflicting on her own children the same sort of treatment she had received from her parents; finally, that her parents treated her as they did, not through malice, but probably because of their own guilty feelings. Patient responded very favorably to treatment.

Note in this case: (1) The general practitioner's advantage over the specialist, in his ability to know several generations of the patient's family, and (2) the self-perpetuating nature of neurosis, in its tendency regularly to be passed from parent to child. It is to be hoped that improvement in this patient has occurred in time to be of preventive benefit in at least some of her children.

Summary

I have attempted to emphasize the following points in regard to mental illness.

- (1) Mental illness is common.
- (2) In a very real sense, even minor mental illness is serious and incapacitating.
- (3) Much of the illness can be adequately diagnosed and treated by the general practitioner;

and if not treated by him, will mostly go untreated.

(4) Mental illness tends to be passed from parent to child; hence the younger the patient when treated the more potential good can be accomplished.

(5) Methods of diagnosis and treatment are briefly discussed, and an illustrative case presented.

The practice of minor psychiatry can bring great satisfaction to the general practitioner. Many times

we feel insignificant in the light of modern advances in specialized fields of medicine, in which we can participate only indirectly, such as cardiac surgery, curative treatment of cancer, and many others, but if one can be of real help to a person lost in the anguish of emotional illness—especially if that person be a young person—he can have the satisfaction of knowing he has rendered one of the greatest services any physician can perform.

Clinic Avenue

THE FIGHT FOR BETTER HEALTH

Extension of Remarks of

Hon. James C. Davis

of Georgia

in the House of Representatives

Monday, April 20, 1959

Directly from the Congressional Record

MR. DAVIS OF GEORGIA: Mr. Speaker, 12 distinguished physicians from my State met at luncheon in the Speaker's dining room here last Thursday with the Georgia delegation and with our Governor, the Honorable S. Ernest Vandiver, to discuss the Nation's sick and aged, and what the medical profession is doing about this continuing problem.

We, the members of the Georgia delegation, were made proud over the farsighted attitude of our Georgia physicians. In opening the discussion, Dr. Eustace Allen of Atlanta, chairman of the Medical Association of Georgia's National Legislative Committee, made a few remarks that reflected the group's constructive perspective.

Dr. Allen's statement follows:

We, the representatives of the Medical Association of Georgia, consider this an honor and a distinct pleasure. For you to give of your time to come and sit down with us and to discuss some of the mutual problems of Georgia, we are grateful. Today, health is the most prominent subject of our country. We realize that health is something that money cannot buy. Good health and good sense are two of life's greatest blessings. Sometimes health and sickness are used synonymously, and the word health has many different meanings. Any program which has to do with health or sickness has a great appeal to the public. Everyone sympathizes with those who are ill or handicapped physically or mentally. The emotional appeal is great. So great that we often decide issues on emotional grounds rather than on facts and figures. There has been sickness since the beginning of mankind. Medicine is the oldest profession. Elbert Hubbard once said that sin and ignorance are the cause of the three learned professions: ministry, law, and medicine. We are going to have illness as long as we have sin and ignorance.

Today, we the people are aroused as never before in this fight for a better health, less sickness, and a stronger nation. No nation can survive and no people can be happy without health. One of our great problems today is our aging population. The American Medical Association

has set forth means and money to study the health problems of our aging population; the President of the United States has a committee studying the problem. The Senate and the House of Representatives have committees making similar studies. Exhaustive studies are essential to arrive at the proper recommendations for a solution. It seems to me it would be best to delay legislative action until these reports are in and evaluated and then we will know "whither we goeth." No stroke of the pen nor passing of a law now, or at any time in the future, is going to do away with sickness.

We are here today because we have a mutual interest in the common good of our people. Mutual confidence and cooperation are the only hope for civilized and productive relationships among ourselves and among nations. The breeding place of misunderstanding and conflict is the closed mind. I fear that is why the medical profession today is on the defense. We had a belief that if we did our job well; if we took care of the sick; if we improved medical care for the community, then our work was done. We did not realize that we should report to the public. We have not explained to the people what we are doing to improve health of the nation and what progress we are making in the care of the aging. We failed when we did not take the people into our complete confidence. We unfortunately thought results would speak for us. Our nation is the best medically cared for in the world. But to tell people, who are sick, that we have the best medical care in the world, does not go well. They reply, "If you have the best medical care and improved health, why am I sick?" All causes of illness, high cost of medical care, hospital cost, etc., erroneously are blamed on the physician.

We are here to offer our help to you the lawmakers, and at the same time we ask you to help us by guiding us in the ways of political service and community well-being. We know we must have positive action to solve our medico-economic situation. We are here to cooperate and at the same time seek guidance and advice.

Again let me thank you for coming and ask you to call on us for any assistance you feel we can give.

YELLOW PIGMENTATION OF THE SKIN AND SCLERAE ASSOCIATED WITH NOVOBIOCIN® ADMINISTRATION

Edwin C. Evans, M.D. and Wyman P. Sloan, Jr., M.D., *Atlanta*

Three patients in this report developed abnormal pigmentation two to four days after initiation of therapy.

SINCE NOVOBIOCIN® WAS FIRST marketed in 1956, it has been widely accepted as a useful antibiotic, particularly in the treatment of resistant staphylococcal infections. Significant undesirable side effects, (skin lesions, loose stools, fever, nausea, and vomiting), were reported in 12.7 per cent of 308 cases when the drug was first clinically evaluated.¹ During the past three years, there have been occasional occurrences of leukopenia^{2,3,4} and eosinophilia.^{2,5} One case each of agranulocytosis,⁶ thrombocytopenia,⁷ and hepatic necrosis¹ due to Novobiocin® has been reported.

The purpose of this report is to call attention to the fact that patients taking this drug may occasionally develop yellowish pigmentation of the skin and sclerae which is indistinguishable from jaundice due to various disease states. We have recently encountered three cases of "jaundice" which were apparently due to the administration of Novobiocin®. Although this side effect is well known to the pharmaceutical groups who produce and distribute the drug, we do not feel that it has been sufficiently emphasized to the medical profession.

Case I

W. T., a 41 year old physician, was first seen on September 19, 1958, with an acute complaint of jaundice which had been noted a few hours before. Eight days previously he developed a furuncle on the thigh with moderate surrounding cellulitis. The infection progressed in spite of self administration of tetracycline and erythromycin. A culture from the lesion yielded hemolytic staphylococcus aureus, coagulase positive, which was highly sensitive to Novobiocin®. Three days before the development of

"Jaundice," Novobiocin® was begun in a dose of 500 milligrams every six hours. The medication was continued until the onset of the jaundice. He was completely asymptomatic at the time that the yellowish discoloration of the skin and sclerae was first noted except for the continuation of the furuncles. There had been no change in the color of the urine or stool. There was no family history of jaundice and there had been no recent dental procedures, needle punctures, or exposures to hepatotoxic agents or jaundiced patients.

On physical examination no significant abnormalities were found except obvious jaundice of the skin and sclerae, and furunculosis of the thigh associated with a mild lymphadenopathy. The liver edge was palpable at the costal margin on deep inspiration but was not tender.

The only abnormalities in a battery of laboratory tests were an elevation of the indirect serum bilirubin and a four plus cephalin flocculation test. The serum bilirubin was 4.8 milligrams per cent indirect and 0.4 milligrams per cent direct. A complete blood count and urinalysis revealed no abnormalities. The thymol turbidity was 0.9 units, serum albumin 3.7 grams per cent, globulin 2.1 grams per cent, blood cholesterol 223 milligrams per cent with 130 milligrams per cent of cholesterol esters, alkaline phosphatase 4.8 King and Armstrong units, and a serum glutamic oxalacetic transaminase of 2.0 units. Repeated urinalyses were negative for bile and showed normal amounts of urobilinogen. The reticulocyte count was 0.9 per cent. The blood smears were reviewed by a hematologist, Dr. Harrison Reeves, who noted no abnormalities in the peripheral blood.

Three days after the above laboratory studies

YELLOW PIGMENTATION / Evans

were done, the serum bilirubin was repeated and found to be 1.2 milligrams per cent indirect and 0.2 milligrams per cent direct. The clinical jaundice rapidly cleared without treatment, and the patient remained asymptomatic.

Comment

This patient developed the jaundice after three days of Novobiocin® therapy. The only abnormalities in the laboratory studies were an elevation of the indirect serum bilirubin and a four plus cephalin flocculation test. In spite of the positive cephalin flocculation test the clinical picture as a whole was not that of hepatitis. The normal serum glutamic oxalacetic transaminase was corroborative evidence that there was no significant degree of liver cell necrosis. No evidence of a hemolytic process could be found to account for the elevated indirect serum bilirubin.

Case II

J. D., a 17 year old student, was seen in the office on June 1, 1957, with the chief complaint of "jaundice" of three days duration. One week previously, he developed a febrile illness characterized by chills, fever, headache, and generalized myalgia. He was seen at home and given an injection of an antibiotic and subsequently placed on a mixture of penicillin and Novobiocin®. The symptoms of the febrile illness subsided and he became asymptomatic at the end of four days. At that time his family first noted that "his eyes were yellow" and an icteric tinge to the skin was noted. The stools and urine had remained normal in color. There was no nausea, vomiting, anorexia, or pruritus. He gave no history of previous jaundice, exposure to the hepatotoxic chemicals or drugs, previous administration of blood or plasma, or needle injections within recent months (except for the parenteral antibiotic given at the onset of the present illness).

Laboratory work done elsewhere the day prior to his visit to the office had shown a normal hemogram. The serum bilirubin was 2.6 milligrams per cent indirect and 0.05 milligrams per cent direct. The cephalin flocculation was three plus and the thymol turbidity 5.8 units. The urine was negative for bile.

Physical examination was negative except for moderate icterus of the skin and sclerae, minimal posterior cervical lymphadenopathy and a functional pulmonic systolic heart murmur.

Subsequent laboratory work on June 6, 1957, revealed a hemoglobin of 15.6 grams, rbc 5,520,000, wbc 9,200 with a differential count of 51 per cent lymphs, two per cent monocytes, 42 per cent polys, and four per cent eosinophils. The heterophile agglutination was positive in a dilution of one to

eight. Direct and indirect Coombs tests were negative. The reticulocyte count was 0.5 per cent, cephalin flocculation two plus, thymol turbidity 7.7 units, serum bilirubin 0.45 milligrams per cent indirect and 0.05 milligrams per cent direct. Urine was negative for bile on repeated examinations.

No treatment was given except for bed rest and the omission of the Novobiocin® preparation. The patient remained completely asymptomatic during subsequent follow up. The clinical icterus cleared within two days after the cessation of the Novobiocin®.

Comment

This patient presented a picture of acholuric jaundice with slight derangement of liver function tests and no evidence of hemolysis. He was completely asymptomatic at the time of the development of the icterus and the yellowish discoloration of the skin and sclerae clinically cleared rapidly after the omission of the Novobiocin®. It was initially thought that this patient might have constitutional hepatic dysfunction; however, there was no history of previous jaundice. Both clinical and laboratory findings in this case are similar to the other cases of jaundice that have appeared after administration of Novobiocin®.

Case III

J. D., a 15 year old white male, was seen in the office on September 9, 1958 with a history of fever, chills, and myalgia four days previously. His physician was consulted and an antibiotic containing penicillin and Novobiocin® was prescribed. His mother had first noticed a yellowish discoloration of the skin and sclerae the day of his first office visit. There was no previous history of jaundice, exposure to hepatotoxic drugs or chemicals, or to infectious hepatitis. Six months previously he had received an injection of polio vaccine and two months previously a tetanus toxoid booster.

He had no specific complaints at the time of the office visit except for the "jaundice." He had noted no change in color of the stools or urine. There was no pruritus, nausea, vomiting, or anorexia.

Physical examination was completely negative except for the apparent icterus of the skin and sclerae.

A routine urinalysis was negative and the urine was negative for bile. Other laboratory work on September 9, 1958, revealed a hemoglobin of 15.7 grams, wbc 8,650 with 58 per cent polys, 32 per cent lymphs, four per cent monocytes, and six per cent eosinophils, thymol turbidity 1.1 units, cephalin flocculation one plus at the end of 48 hours, alkaline phosphatase 5.2 King and Armstrong units, serum bilirubin 1.8 milligrams per cent indirect and 0.4 milligrams per cent direct. The clinical

icterus was rapidly clearing at the time of these laboratory procedures. On September 11, 1958 the indirect bilirubin was 0.75 milligrams per cent and direct, 0.15 milligrams per cent.

No specific treatment was given except for the omission of the Novobiocin.[®] The jaundice cleared rapidly and he remained asymptomatic.

Comment

This patient developed a yellowish discoloration of the skin and sclerae shortly after the administration of an antibiotic containing Novobiocin.[®] His serum bilirubin elevation was entirely in the indirect fraction. There was no evidence of hemolysis. Liver function tests were normal. The icterus rapidly cleared after the omission of the antibiotic.

Discussion

The administration of Novobiocin[®] to dogs in a single dose of 100 milligrams per kilogram is followed in three hours by yellowish coloration of the plasma which reaches a peak in 12 hours and disappears in 18 hours.² This pigment can be removed from the plasma by extraction with neutral ethyl acetate or with chloroform at a pH of 7.5-8.0.^{8,9} Serum bilirubin will not be removed readily under these conditions. Evidence based upon this differential feature points to the fact that the yellow pigment produced after the administration of Novobiocin[®] is a metabolic by-product of the antibiotic and is not bilirubin. Although mild focal necrosis of the liver has been produced in experimental animals after the administration of massive doses of this antibiotic,² there is little evidence that it is a hepatotoxic drug.

Patients receiving therapeutic doses of novobiocin have also been noted to occasionally develop this yellowish pigmentation of the skin, sclerae and plasma.^{2,10,11} In most instances, these individuals have received more than one gram of the antibiotic daily. Welch, et al.¹⁰ however, have noted this pigmentation in three of 308 subjects receiving one gram or less of Novobiocin[®] daily. This pseudo-jaundice usually appears on the second or third day of medication. The characteristic finding has been that of an elevated indirect serum bilirubin and the absence of evidence of hemolysis or hepatic dysfunction.

The three patients presented in this report were thought to represent instances of "icterus" due to Novobiocin[®] therapy. In each instance, the patient developed a yellowish discoloration of the skin and sclerae two to four days after the initiation of Novobiocin[®] therapy. In each instance, the individual was completely asymptomatic at the time that the apparent "jaundice" developed. The clinical icterus rapidly disappeared within two to three days after

the cessation of administration of the drug. Laboratory findings were those of an acholuric jaundice with absence of bile in the urine and an elevated indirect serum bilirubin with a normal direct fraction. No evidence of hemolysis could be found. Two of the patients exhibited isolated disturbances in liver function tests; however, the clinical course was not that of hepatitis. Clinical jaundice rarely clears in less than ten days in infectious hepatitis or homologous serum hepatitis. Although the indirect serum bilirubin fraction may recede slower than the direct in the clinical course of hepatitis, and may remain slightly elevated after the direct fraction has receded to normal, this laboratory finding usually appears late—days or weeks after the onset of the jaundice. The absence of bile in the urine, normal urobilinogen, normal transaminase in the one instance in which it was performed and a lack of elevation in the direct bilirubin fraction, are all incompatible with the diagnosis of hepatitis.

Summary

Three cases of a pseudo-jaundice due to a pigmented metabolite of Novobiocin[®] have been presented.

The characteristic finding is the development of an apparent icterus of the skin and sclerae two to four days after the initiation of Novobiocin[®] therapy in an individual who is otherwise asymptomatic and who presents laboratory findings of an acholuric jaundice without evidence of hemolysis.

Addendum

Since the preparation of this report an additional case has come to our attention. A sixteen year old male student, a private patient of Dr. Charles Jones, received oral penicillin and Novobiocin[®] for an infection of the hand with lymphangitis. On May 21, 1959, he received 0.75 grams of Novobiocin[®] and on May 22, 23, and 24 he received 1.5 grams of Novobiocin[®] daily. Icterus was observed on May 24. On May 25 total serum bilirubin was 4.9 mgm. per cent with 4.16 mgm. per cent indirect and 0.74 mgm. per cent direct. Novobiocin[®] was discontinued at this time. The following day the total serum bilirubin was 4.5 mgm. per cent with 4.0 mgm. per cent indirect. The thymol turbidity was 3.0 units and serum glutamic oxalacetic transaminase was 16 units. Urine was negative for bile. On May 30, 1959, the total serum bilirubin was 2.0 mgm. per cent, all of the indirect type. The reticulocyte count was 0.3 per cent; urine was negative for bile and contained normal quantities of urobilinogen. There was no hepatic or splenic enlargement and no family history of jaundice.

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NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County</i>	<i>Society</i>
Becker, Folke	VA Hospital Dublin, Georgia	Service	Laurens	
Bedingfield, Wade Ramsey, Jr.	Louisville Street Harlem, Georgia	Active	Richmond	
Blue, Jacob S.	WRAMA Robins AFB, Georgia	Service	Peach Belt	
Brandes, Peter	VA Hospital Dublin, Georgia	Service	Laurens	
Brennan, Carl H.	4 Medical Arts Center Savannah, Georgia	Active	Georgia Medical Society	
Bronson, Sylvester Martin	VA Hospital 4158 Peachtree Rd., N.E. Atlanta 5, Georgia	Service	Fulton	
Burch, Earl S.	VA Hospital Dublin, Georgia	Service	Laurens	
Chambless, William House	Crawford W. Long Hospital Atlanta 8, Georgia	DE 2	Fulton	
Connell, Harlow Richard D., Jr.	Harbin Clinic Rome, Georgia	Active	Floyd	
Crump, George Curtis	VA Hospital Dublin, Georgia	Service	Laurens	
deJuan, Eugene	Grady Memorial Hospital Atlanta, Georgia	DE 2	Fulton	
Dosher, William S.	VA Hospital Dublin, Georgia	Service	Laurens	
Dulin, Samuel N.	VA Hospital Dublin, Georgia	Service	Laurens	

NEW MEMBERS OF MAG CONTINUED

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Eubanks, William M., Jr.	Georgia Baptist Hospital Box 337 Atlanta 12, Georgia	DE 2	Fulton
Everett, Jerry J.	Memorial Hospital of Chatham County Savannah, Georgia	Active	Georgia Medical Society
Fraser, Whitman	Fraser Lane Hinesville, Georgia	Active	Chatham
Gregoroff, Stanley	35 Linden Avenue, N.E. Atlanta 8, Georgia	DE 2	Fulton
Hadaway, William Hugh	200 Church LaGrange, Georgia	Active	Troup
Hamilton, Walton Winslow	1143 Druid Park Augusta, Georgia	Active	Richmond
Hodges, Thomas Lumpkin, Jr.	Habersham Medical Group Clarkesville, Georgia	Active	Habersham
Jones, Edward G.	VA Hospital Dublin, Georgia	Service	Laurens
Juliano, Aniello Anthony	VA Hospital Dublin, Georgia	Service	Laurens
Madry, James Thomas	285 Boulevard, N.E. Atlanta 12, Georgia	DE 2	Fulton
Major, Cecil Paul	303 Smith Street LaGrange, Georgia	Active	Troup
May, Robert Donald	1205 Roswell Street Marietta, Georgia	Active	Cobb
Mc Fall, Voris Francis	2795th USAF Hospital Robins AFB, Georgia	Service	Peach Belt
Mendeloff, Joseph	VA Hospital Atlanta, Georgia	Service	Fulton
Rodriguez, Josefina C.	VA Hospital Dublin, Georgia	Service	Laurens
Scott, Morgan Eugene	VA Hospital Dublin, Georgia	Service	Laurens
Schley, Mary Wheatland	303 11th Street Columbus, Georgia	Active	Muscogee
Sizemore, Julian Jesse, Jr.	1315 Wildwood Avenue Columbus, Georgia	Active	Muscogee
Smiley, David Theodore	Grady Memorial Hospital Atlanta 3, Georgia	DE 2	Fulton
Smith, Luther Jerome, II	1509 Fourth Avenue Columbus, Georgia	Active	Muscogee
Tarbell, Luther A.	VA Hospital Dublin, Georgia	Service	Laurens
Tavener, Michael Chester	VA Hospital Dublin, Georgia	Service	Laurens
Trincher, Irvin Harrison	Veterans Hospital 441 W. Peachtree Street, Atlanta 8, Georgia	Service	Fulton
Webber, Joe Martin	Laboratory, Medical Center Columbus, Georgia	Active	Muscogee

GASTROGRAFIN®: A MEDIUM FOR INTESTINAL ROENTGENOLOGY

The advantages and disadvantages of this new medium are compared with conventional barium sulfate.

David Robinson, M.D., Savannah

“DOCTOR, WHEN ARE YOU going to invent something to take the place of this chalk?” This is the expression we hear so often when we are doing gastrointestinal studies. I am not presenting this paper to describe a new product which will eliminate one of the unpleasant features of conventional barium sulfate studies. However, prior to the development of Gastrografin® (Squibb), we had no alternative to offer to the skittish and less co-operative patient. This does not imply that Gastrografin® will eliminate the occupational hazard of barium sulfate or that it is a complete replacement for it, yet, in certain problem studies of the intestinal tract in which an opaque medium must be used, this new medium has proven helpful.

The older radiologists are well acquainted with bismuth which was the original medium used in intestinal roentgenology. In fact, my former professor, the late Dr. L. P. Holmes often referred to the barium sulfate mixture as “bismuth.” Bismuth was soon replaced by barium sulfate which was found to be more satisfactory.

Davis et al⁴ and Shufflebarger et al¹² have summarized the necessary properties for a satisfactory medium to be used in intestinal roentgenology. They stated that such a medium should remain in solution without settling and permit uniform radiopacity. It should be preferably water soluble but nonabsorbable from the gastrointestinal tract; it should not tend to become inspissated in the intestinal tract; and it should be non-toxic if absorbed.

As several other investigators have attempted to

meet the requirements of an acceptable medium, considerable refinement in the processing and manufacturing of barium sulfate was carried out. Some workers have shown that smaller particles of barium sulfate have a distinct advantage in gastrointestinal studies.^{1,14} This is a controversial issue and is still subject to the needs and requirements of the individual radiologist. Some authorities^{4,12} feel there is little advantage in using barium sulfate with a particle size less than BaSO₄, U.S.P.

We are aware of the potential and real hazards that may occur when barium sulfate is used in intestinal roentgenology. Among such hazards are the introduction of barium into the peritoneal cavity via a ruptured ulcer and the perforation of the colon during enema studies with a secondary pulmonary embolism.^{6,8,11} I have recently observed a case of perforation of the ileum in regional enteritis following a small bowel study in which barium sulfate was used. There was a resulting extravasation of barium into the peritoneal cavity. The danger of aspiration of barium sulfate in children is well known, particularly in tracheoesophageal lesions and pyloric stenosis. The danger of barium granuloma of the rectum has been reported.¹³ The less serious but rather annoying complaint of rectal impaction following the use of barium sulfate confronts all of us using this medium and the patient is prone to attribute many of his previous and past symptoms on the “white balls” that he tried to deliver per rectum.

The use of water soluble, non absorbable media other than Gastrografin® has been reported by Epstein,⁵ Canada,² and Davis et al.³ These other media have the disadvantage of having less density

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than barium with poorer coating of the mucosal surface. In addition, these media have such extreme bitterness that it is necessary to administer them via stomach tube when given by mouth. Gastrografin® is the first such medium to be prepared specifically for this use. The medium is more palatable and permits direct ingestion.

Gastrografin® is a 76 per cent aqueous solution of Renografin® (Squibb: diatrizoate methylglucamine adjusted to neutrality with sodium hydroxide) which has been flavored and sweetened for improved palatability. It contains polysorbate 80 U.S.P. and an antifoaming agent to aid dispersion into mucosal folds. The contrast medium has been tested on dogs with no evidence of toxic effects and only traces of iodine were recovered in serial urine samples.⁹

In July, 1958, a report was published describing our original investigation of this medium.¹⁰ This report included a series of 41 upper gastrointestinal studies, one small bowel study, and six colon studies. Since completing the original series, I have carried out over 200 examinations using this medium and the results confirm our original findings.

Orally, the medium can be given in a 1:1 dilution in the 150 pound patient using milk, water, or carbonated beverages as the diluent. For heavier patients, the undiluted medium should be used. I found that 50 to 100 cc. are adequate for filling the stomach and duodenum. In colon studies, 600 cc. of a 1:1 dilution was adequate to fill the entire colon.

Indications for Using Gastrografin®

The indications for using Gastrografin® in preference to barium sulfate are usually those factors in which barium sulfate is found to be undesirable. In obstruction of the small bowel, Gastrografin® can be used to obtain information of the size and location of small intestinal loops without danger. As it is water soluble, it can readily be removed via suction tube. In emergencies, immediately prior to surgical exploration, it can be given without danger of inspissation. In partial obstruction it can be used without the danger of causing a complete obstruction. In infants with pyloric stenosis or tracheoesophageal fistulae, it can be used without the danger of aspiration. In cases of diverticulosis of the colon, it can be given as an enema without the danger of a perforation resulting in barium peritonitis. A recent case of chronic perforation of the bowel proved to be very select for this type of media. It was one in which I was afraid that the use of barium sulfate would have resulted in serious sequelae. I should also like to point out a very practical application for

the use of this medium for those of us who are forced to examine patients as rapidly as possible. This is true in those cases in which the referring clinician is uncertain whether the pathology is in the upper or lower intestinal tract and where he elects to order the upper gastrointestinal study initially to be followed by the colon study if the initial study is negative. I have found that the medium can be given by mouth one day and the colon study carried out the following day, if necessary, without the handicap of having barium in the colon of an unprepared patient. We realize the difficulty of preparing a patient for a colon examination the next day following an upper gastrointestinal series using barium sulfate. I feel that the elderly patient who usually has stasis of the colon will have less difficulty when Gastrografin® is used in upper gastrointestinal studies. Certainly, this would be the medium of choice in those cases where an impending perforation of the stomach or duodenum is suspected due to peptic ulcer.

The advantages of Gastrografin® includes its uniformity of radiopacity. It does not settle on standing; is readily available and requires no preparation; and has safety in procedures where barium sulfate is contra-indicated. In many cases, it is more accurate and better tolerated than barium sulfate.

Disadvantages in Using Gastrografin®

Some disadvantages to the use of Gastrografin® are seen in several areas of examination. In the esophagus, the medium moved too rapidly and inadequate visualization resulted. To offset this, the medium can be prepared with a gelatin base such as Jello.® In the stomach, there is at times noted a reflex spasm which occurs in about 20 per cent of the cases. This occurs after the passage of the medium into the small bowel. As yet, this has not proven to be a serious problem. In the small bowel, due to the osmotic action of the dye, there is a dilution of the medium and visualization of the small bowel is not as satisfactory as with barium sulfate. Therefore, it is possible to overlook all but the larger lesions in this area. In the colon, the inability of the patient to evacuate the medium well is somewhat a disadvantage in its use. It is probable that the lack of a bulk stimulus results in this shortcoming.

In pyloric stenosis and small bowel obstruction, the lowered viscosity of the medium has been considered as a possible disadvantage in that in these conditions, it is possible that the dye may pass through the small opening giving a false impression of patency and non-obstruction. I have failed to encounter this disadvantage in my own experience

with this medium. One real disadvantage to its use is its relative high cost as compared with barium sulfate. The medium costs about ten times more than conventional barium sulfate preparations.

As of this time, there have been no cases reported wherein there has been proven toxicity. Several patients have complained of significant diarrhea as well as vomiting. The former was readily controlled by using paregoric. All of the patients examined tolerated the medium although some have complained about its bitterness. Some patients who have had both barium sulfate and Gastrografin® preferred the latter. Due to its iodine content, caution should be considered in using it in those cases of severe hepatocellular or renal cell damage. I have seen no cases of iodism.

Summary

Gastrografin® is a safe and readily available medium that has proven to be satisfactory in use in intestinal roentgenology. In certain cases where barium sulfate is contra-indicated, it can be used safely. In other cases, it has been found to be superior to barium sulfate. I have reviewed the advantages and disadvantages of this new medium and compared them with conventional barium sulfate. The results of its use in over 200 clinical cases are presented.

No. 9 Medical Arts Center

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11th ANNUAL MEETING OF THE GEORGIA HEART ASSOCIATION

FIVE NATIONALLY-KNOWN PHYSICIANS in the cardiovascular field have been announced as speakers to the 11th Annual Meeting and Scientific Sessions of the Georgia Heart Association.

The Scientific Sessions are set for September 11 and 12 in the General Oglethorpe Hotel, Savannah. The sessions, open to all doctors, are approved for credit under Category I by the Georgia Academy of General Practice.

Josephine Buchanan, M.D., Chief Department of Physical Medicine and Rehabilitation, Georgetown University, Washington, D.C., will speak on "Management of the Stroke Patient in Hospital and Home" and "Potentials for Rehabilitation of the Stroke Patient."

E. Stanley Crawford, M.D., Assistant Professor of Surgery, Baylor University College of Medicine, Houston, Texas, will offer papers on "The Surgical Treatment of Cerebral Arterial Insufficiency" and "The Surgical Treatment of Acquired Diseases of the Aorta and Iliac, Femoral, and Popliteal Arteries."

Herman K. Hellerstein, M.D., Assistant Physician,

University Hospitals, Cleveland, Ohio, will present papers entitled "The Mechanism of Death in Coronary Artery Disease" and "On-the-Job Cardiac Function of Surgeons, Factory, and Foundry Workers."

John B. Hickam, M.D., Professor of Medicine and Chairman of the Department of Medicine, Indiana University School of Medicine, Indianapolis, Indiana, will present papers on "Pathological Physiology and Treatment of Cor Pulmonale" and "Some Observations on the Effects of Cardiovascular Disease on the Optic Fundus."

Clark H. Millikan, M.D., Consultant in Neurology, Mayo Clinic, Rochester, Minn., will speak on "The Medical Management of Various Types of Strokes" and "Recent Advances in the Study of Cerebral Atherosclerosis."

For further information about the Georgia Heart Association Scientific Sessions and for registration forms, write the Georgia Heart Association, 1101 West Peachtree Street, N.E., Atlanta 9.

INSTILLATION OF NITROGEN MUSTARD IN BODY CAVITIES FOR TREATMENT OF METASTATIC CANCER

Eight cases are reported in which encouraging results are described.

Edgar D. Grady, M.D., *Atlanta*

THE AIM OF TREATMENT of incurable cancer is to control the disease with minimal side effects of the treatment. The instillation of nitrogen mustard into body cavities containing surface malignant cells approaches this aim. When this agent contacts cancer cells, there is seen an effect similar to the effect of X-rays. In the same way as the irradiation, nitrogen mustard attacks the most actively proliferating cells with which it comes in contact. This would explain why it is useful in treatment of rapidly proliferating cancer cells. It would also explain why it destroys the normal rapidly proliferating bone marrow cells. In sufficiently high concentrations, such substances will also damage or destroy normal tissue cells.

When nitrogen mustard gets into the general circulation, it produces depression of the blood forming elements, resulting in anemia and leukopenia, the degree depending on the amount of the drug contacting the cells concerned. In addition, symptoms of nausea and vomiting (probably on the basis of direct effect on central nervous cells) will be produced when this drug enters the general circulation. These factors emphasize that we need to concentrate our drug where it is needed only. The applications of this principle include: local instillation of nitrogen mustard into a body cavity containing surface malignant cells,^{1,2,3,4,5} injection of nitrogen mustard into catheters placed in the arterial supply of inoperable cancer masses,^{6,7,8} and perfusing an isolated section of the body by the pump oxygenator technique.^{9,10,11} This report is concerned with the first method.

When nitrogen mustard is instilled in the pleural cavity, the pericardial space or the peritoneal cavity

where malignant, rapidly proliferating cells are present on the serosal surfaces, the drug in appropriate concentration produces death of the malignant cells, only slight damage to the normal living cells and relatively no damage to the hemopoietic system. The symptoms of nausea and vomiting are much less than when the drug is introduced into the general circulation. Apparently, a relatively small amount of nitrogen mustard escapes into the general circulation in the few minutes in which the active effective form is present. Within a few minutes after injection into the body, nitrogen mustard undergoes chemical transformation, combines with reactive compounds, and is no longer present in active form.¹⁰

The use is limited in body cavities to cases containing effusion of fluid in which the drug may be injected for the necessary dilution and spreading. Meticulous care must be used to inject into a free connection with the fluid. To put a high concentration in a tiny pocket or worse, into the soft tissue of the body itself, would spell disaster. Necrosis of the involved tissue would occur. This has been demonstrated when a dose as small as 2 mgs. was injected into a catheter which had accidentally slipped out of the artery where it had been placed for intra-arterial administration.⁶

The technique for administration is based on the above analysis. When injecting into the peritoneal cavity in the case of ascites produced by metastatic disease, a paracentesis is accomplished with a large needle (about #13 to #15). Only the excess fluid necessary to relieve pressure is removed. Then, a polyethylene catheter is passed through the needle into the peritoneal space. It is verified that the catheter's distal end is lying free in the space con-

taining the fluid. The calculated dose is then injected and the catheter irrigated with saline or ascitic fluid that has been collected. The same technique is used to inject mustard into a pleural or pericardial space.

An additional use of the same drug used in a similar fashion is to prevent seeding of cancer cells at time of operation in both the thoracic and abdominal spaces. When the chest or abdominal cavity is closed, one end of a polyethylene catheter is left in the free space, the other end brought out through the incision which is closed around the catheter. Medication is then injected into the space, the catheter is irrigated and withdrawn. If a biopsy is taken of a lesion at the time of operation for frozen tissue examination, there is some possibility that malignant cells may be spilled. If tumor is adherent to either pleura, pericardium, or peritoneum, there is some likelihood that a few cells may be spilled in the process of dissection or that a few malignant cells may be left behind. Local instillation of nitrogen mustard would be likely to destroy such cells and decrease the probability of local recurrence of disease.

There are several reports in medical literature describing the application of intracavitary nitrogen mustard for treatment of effusion. It was first suggested by Karanosky² in 1948 and first reported as being used successfully by Albert Telli in Argentina. In addition, Fullerton and Reed,² Taylor,⁴ Skinner and Carr,⁵ Wisenberger, et al,¹ have reported numerous cases. In Wisenberger's 43 cases (30 pleural, 11 peritoneal, and two pericardial) 28 were significantly improved. In 20 patients, no more fluid was formed, and in eight, there was a great reduction in quantity. He found best response in cancer of the ovaries and breast. One patient was followed as being alive and well 24 months after therapy. Three others were apparently well 12 months after treatment. Six additional patients remained asymptomatic for six to ten months after treatment. In the pericardial space, 10 mgs. of nitrogen mustard diluted in 10 cc. of saline were used. In the thoracic and abdominal cavities, 4 mgs. per kilogram was the dose.

The author wishes to report eight cases in which nitrogen mustard has been injected into pleural and peritoneal cavities with a varying amount of success in each case.

Case I

S. H. — Generalized undifferentiated adenocarcinoma of the abdominal cavity with large amounts of ascites was present in this patient who was given 20 mgs. of nitrogen mustard intraperitoneally on two occasions. The amount of fluid was greatly diminished for five months until death from generalized disease.

Case II

L. A. — This patient had generalized abdominal cavity adenocarcinoma from the ovary and had received 40 abdominal taps in a year to control the symptoms of ascites. The installation of 20 mgs. of nitrogen mustard on three occasions diminished her necessity for paracentesis to one time per month in the last six months of life.

Case III

G. A. — Leiomyosarcoma of the terminal ilium had metastasized since the primary resection so that the generalized peritoneal implants produced large quantities of fluid. A single injection of 20 mgs. of nitrogen mustard decreased formation of fluid throughout the last seven months of life.

Case IV

D. N. — Squamous cell carcinoma of cervix after radiation treatment had metastasized to the abdominal cavity to produce moderate ascites. Patient appeared to have severe advanced disease, but nevertheless, 20 mgs. of nitrogen mustard were instilled in the peritoneal cavity. There was some temporary decrease in swelling and improvement in the abdominal symptoms prior to the death about six weeks later.

Case V

R. S. — This patient had recurrent massive disease in the pelvis following X-ray therapy for papillary cystadenocarcinoma of the ovary given four years previously. She had very poor nutrition of suprapubic abdominal skin in the area of the previous surgery and irradiation. Reoperation removed all the gross disease, but obvious tumor was spilled into the abdominal cavity during the operation. Twenty mgs. of nitrogen mustard were instilled in the abdominal cavity at the conclusion of surgery. Some of the free fluid containing the nitrogen mustard was allowed to contaminate the wound prior to its complete closure. Postoperatively there was a loss of some of the skin around the wound, but healing was eventually completed. The patient has had no proof of recurrent disease during the 16 months after the operation. One ureter has some constriction, but this has remained unchanged and is thought to be due to scarring.

Case VI

C. E. — This patient was treated by left pneumonectomy for a bronchogenic carcinoma, which originated in the left upper main stem bronchus, extended into a large part of the pericardium and the adventitia of the pulmonary vein, and involved the perineural lymphatics and peribronchial lymph nodes. In order to get around gross disease, a large

part of the pericardium was removed, and a cuff of auricle was excised *en bloc* with the lung. From the appearance of the extent of disease, the likelihood of local recurrence seemed great. Ten mgs. of nitrogen mustard were given intravenously preoperatively, and on two occasions in the early postoperative period. Twenty mgs. of nitrogen mustard were injected into the pleural space two days after surgery. In the 12 months after surgery, there has been no evidence of disease recurring in the chest. There has developed metastatic disease in the lumbar vertebrae.

Case VII

J. C. R.—This 53 year old, white male had a left upper lobectomy on June 17, 1958 for an apical lesion of the lung. At operation, the lesion was found adherent to the parietal pleura in every direction. Preoperative bronchoscopy and scalene fat pad biopsy had failed to prove the diagnosis. A biopsy of the primary lesion was taken at the time of thoracotomy and by frozen section was shown to be malignant. Permanent sections demonstrated squamous cell carcinoma grade three to four, with extension to pleura. At the time of surgery, a large block of parietal pleura was removed with the lung specimen. It seemed highly possible that tumor cells could have been spilled into the open wound at the time of surgery (either at time of biopsy or in the process of removing parietal pleura). Therefore, the wound was closed around a polyethylene catheter and immediately after surgery, 10 mgs. of nitrogen mustard were instilled into the pleural space. Three weeks after surgery, when the wound was healed, a course of deep X-ray therapy was given to the apical area, supra clavicular area and mediastinum. There has been no evidence of recurrence of the disease to date.

Case VIII

Mrs. F.—This 59 year old, white female was treated for inoperable disease of the abdomen and pelvis, which had been demonstrated by laparotomy in September, 1957, to be widespread adenocarcinoma, probably arising in the ovaries. At the time of this paliative therapy, she had a large fixed pelvic mass and a moderate amount of free peritoneal fluid. Her treatment consisted of intermittent intra aortic nitrogen mustard, 10 mgs. per day for four days and 20 mgs. of nitrogen mustard instilled through a polyethylene catheter passed through a paracentesis trochar. The patient's pain, pelvic mass, and ascites all decreased greatly after treatment. She did require transfusions for bone marrow depression.

Conclusions

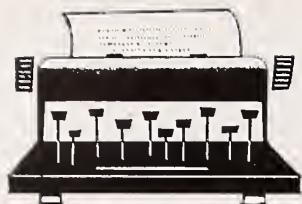
The injection of nitrogen mustard into body cavities (pleural, pericardial, and peritoneal) is useful in producing death of malignant cells with which the mustard might come in contact. This is applicable in two situations here reported. Injection of nitrogen mustard may be useful in controlling the production of fluid produced by metastatic cancer to the cavity lining. It is further useful immediately postoperatively used in the same way, to prevent seeding by cancer cells suspected to have been spilled by biopsy or dissection through tumor. In any case, it is advisable to inject through polyethylene catheters placed in the free spaces of the cavities, either through trochars or at time of operation. The dosage recommended for each site is: 20 mgs. for peritoneal cavity, 20 mgs. for peritoneal space, and 10 mgs. for pericardial space. There are few side effects or local complications when nitrogen mustard is injected into these free spaces according to the dosage and technique recommended.

1938 Peachtree Road, N.W.

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**See Page 275 for
Full Report of the
Milledgeville Study Committee**



editorials

Hatcher New President-Elect

MILFORD BURRISS HATCHER, Macon, was named by the Medical Association of Georgia to serve as president-elect for the year 1959-60.

A native of Georgia, Dr. Hatcher is a graduate of Furman University. He received his M.D. degree from the Medical College of Georgia in 1935 and served his internship at the University Hospital in Augusta.

He practiced general surgery in Macon from 1939 to 1940. From 1941 to 1946 he served in the Medical Corps of the U. S. Army as a Lt. Colonel. He returned to Macon in 1946 and resumed his practice in General Surgery. He presently holds the positions of Chief, first surgical section Macon Hospital; attending surgeon Middle Georgia and Parkview Hospitals; consultant in surgery at the Milledgeville State Hospital, Upson County Hospital, Monroe County Hospital, and Jasper Memorial Hospital. Dr. Hatcher is past Chief of Staff of Macon Hospital and Past Chairman of Macon Hospital Executive Committee.

He is a member of the American Medical Association, Sixth District and Bibb County Medical Societies. He has served as president of the Sixth District and Bibb County Medical Societies, past vice-president of the Medical Association of Georgia, and is a member of Council and member of the House of Delegates. Presently he is Chairman of the Hospital Relations Committee and Georgia Hospital-Medical Mediation Council and was a member of Governor Griffin's Hospital Study Commission.

Dr. Hatcher is a Diplomate of the American Board of Surgery; Fellow of the American College of Surgeons; Fellow and Diplomate of the International College of Surgeons; Fellow of the Southeastern Surgical Congress; and a member of the



MILFORD B. HATCHER
President-Elect

Industrial Medical Association. He is a member of the Macon Rotary Club; Alpha Omega Alpha, honorary medical fraternity; Kappa Alpha Fraternity; Alpha Kappa Kappa, medical fraternity; and the Macon Elks Club.

Dr. Hatcher helped organize the Highland Hills Baptist Church in Macon in 1953 where he served

as first Chairman of the Board of Deacons and is presently a member of the Board of Deacons and Chairman of the Building Committee.

Because of his accomplishments in the past and his continued interest in civic and medical affairs, Dr. Hatcher has been listed in "Who's Who in the

South and Southwest" and "International Blue Book."

Looking back at Dr. Hatcher's past and present record, the Medical Association of Georgia can truly look forward to a successful year under his leadership.

Milledgeville State Hospital

The Milledgeville State Hospital Report featured elsewhere in this issue represents a unique milestone in the history of medicine in Georgia. It promises to supply the stimulus for a virtual renaissance in providing adequate care and treatment for the mentally ill within our state.

It is ironic that this awakening should be so long delayed. Indeed as early as 1913 a plea was made in the pages of the *Journal of the Medical Association of Georgia* for a change in the public attitude toward mental illness and for better and more complete staffing of the mental hospitals in Georgia. This paper by Dr. Y. A. Yarbrough was followed by 11 other reports over the years that followed outlining the inadequate conditions which prevailed in the Milledgeville State Hospital and making similar recommendations for its improvement.

These inadequate facilities have been well known to most doctors and to many better informed laymen over the state. But in spite of these facts the prevailing widespread public apathy remained apparently unchanged. Those best qualified to make unbiased recommendations for improving the situation were powerless since their counsel was never sought.

With the majority of other states having already made great strides in the care of their mentally ill, the time for the State of Georgia to take similar action seemed long overdue.

Into this seemingly insoluble and deadlocked situation a young reporter for the *Atlanta Constitution* was dispatched to Milledgeville to investigate the institution from a newspaperman's point of view. Many conditions found to prevail at Milledgeville State Hospital by this reporter were startling and provided material for a series of feature articles in

the Constitution. Because of its wide circulation and readership over the State of Georgia, citizens throughout the state were shocked and demanded that something be done. The Governor was quick to arise to the occasion and immediately sought expert advice. At the request of the Governor, the President of the Medical Association of Georgia appointed a committee of five doctors, two of whom were psychiatrists to personally investigate all aspects of the operation of Milledgeville State Hospital with particular attention to be paid to the irregular practices reported in the series of newspaper articles. It was encouraging at the outset that all five doctors who were originally asked to serve on this Committee accepted without reservation. They took leave of their practices and went to work immediately. They served without compensation during the entire period of the investigation and gave unstintingly of their time and energies. These men had the expert aid of the legal counsel of the Medical Association of Georgia throughout the period of the investigation. The legal and stenographic costs were borne gladly by the Medical Association of Georgia.

The superb job that these men have done in the cause of mental health for the State of Georgia cannot be overestimated. The document speaks for itself and will indeed provide a bright spot in the annals of medicine and psychiatry in Georgia. Already positive action has been taken by the Governor toward the reorganization of the state mental hospital and increased allocations are to be made in the state budget to underwrite these changes.

Governor Vandiver is to be congratulated for his forthright stand on the issue and for his wisdom in calling for an immediate investigation by a committee of physicians imminently qualified and with-

out bias. The Medical Association of Georgia is grateful to have had a part in this useful public service and is particularly proud of its members who served so well.

Finally, the citizens of Georgia are to be commended for their manifestation of increased interest in the care and treatment of our mentally ill. It is earnestly hoped that this interest will be sustained in order that our state mental hospital may become an institution of which all Georgians may be proud.

Mouth to Mouth Resuscitation

TIME HONORED TECHNIQUES of artificial respiration have recently been dealt a hearty blow. Within the past several years, research aimed at the evaluation of the effectiveness of such techniques as the Schafer Prone-pressure method, has demonstrated that in the majority of instances ventilation by these means has been woefully inadequate. Tidal exchange, which normally measures a minimum of 300 cubic centimeters in the adult, is most often measured to be 150 cubic centimeters or less with these methods. It would seem that those who have been "resuscitated" by these techniques have indeed been fortunate, or possibly would have survived without artificial respiration.

Elisha may yet become the "prophet of artificial respiration" in view of his experience in "breathing life into a lifeless child." This is probably the first recorded use of mouth-to-mouth resuscitation which now is proving to be the only truly effective means of artificial respiration not requiring special equipment. For many years it was felt that expired air was not sufficient in its oxygen content to support another individual's respiratory demands; and it was felt that the expired carbon dioxide would result in excessive levels in the victim's blood stream if "mouth-to-mouth rebreathing" was maintained for any period of time.

These recent studies have demonstrated rather positively that one individual can supply the oxygen needs of another, without elevation of the carbon dioxide level, through the proper performance of mouth-to-mouth respiration. It has also been shown that more than adequate tidal volumes, ranging between 500 and 1,500 cubic centimeters, can be maintained for rather extended periods. Even a small individual of 100 pounds or less can adequately

ventilate a victim weighing 200 pounds for a surprisingly long period of time without tiring.

As the summer season approaches with its usual hazards involving water sports, we must anticipate that the number of drowning victims will increase, even over the rates of previous years. This will be brought about by the increased number of public and private swimming pools as well as the increased interest in vacations at the beach or lakeside. Many swimming spots are not covered by lifeguards and even those adequately manned by lifeguards are unable to offer 100 per cent protection against drowning.

With the demonstration that such methods as that of Schafer are grossly ineffective, it would seem that each individual allied with the medical profession should make it a point to learn the proper performance of mouth-to-mouth ventilation. Essential points in this technique are that the airway be cleared of any foreign material and that a tight fit be obtained between the operator's mouth and the mouth of the victim. The chin must be supported to prevent the tongue from lying against the posterior pharyngeal wall and the nose of the victim must be held in order to prevent leakage through the nasopharynx. With a little practice all of these maneuvers can be simultaneously performed. The most common cause of failure in this situation is obstruction by the lips or the hesitancy on the part of the operator to obtain a firm seal between his lips and those of the victim.

Naturally there is an esthetic objection to such a technique, even though it is a life-saving procedure. This objection has been overcome by the production of a "double airway" or resuscitation tube. With one of these devices it is not necessary that the operator's

lips touch any part of the victim. One end of the double airway is inserted over the victim's tongue in such a manner as to keep it lying against the pharyngeal wall, the lips are "sealed" over a small flange which divides the two airways, the nose is held closed and the operator then blows into the other airway. The technique is simple to learn and can be mastered by most laymen and physicians after one or two short demonstrations. These airways are available from most supply houses and are quite inexpensive.

It would seem that many lives could be saved this summer if each physician would train the mem-

bers of his family and possibly others in his neighborhood in the proper use of this method. Certainly one or more of these devices should be available at every swimming area or other site of water sports. It has become the practice of some physicians to carry one of these airways in their pockets and in their automobiles, since suffocation is by no means limited to bodies of water. There is certainly no question that previously utilized methods of artificial respiration should no longer be included in the curriculum of first-aid and that steps should be taken to have this simple airway device available wherever the probability of its need exists. **PROVIDE YOURSELF WITH ONE TODAY!**

RESOLUTION ON THE DEATH OF MARVIN M. HEAD

Dr. Marvin M. Head was born October 19, 1880, in Meriwether County, Georgia and died in Zebulon, Georgia, March 31, 1959. His father, a physician, moved his family to Zebulon, Georgia when Dr. Marvin M. Head was a small boy. Dr. Head received his education in the public schools of Zebulon, Gordon Military College and graduated from the Atlanta College of Physicians (now Emory University School of Medicine) in 1902 with the degree of Doctor of Medicine. Soon after he joined his father in the practice of medicine and in operating a drug store in Zebulon, Georgia. He married Miss Susan Anna Dupree in 1904, and in 1905 Marvin Nicholson Head was born to this union.

All who knew Dr. Head remember him as a tireless worker and a physician in the true sense of the word. His life was dedicated to serving his fellow man through the practice of medicine or in any manner in which he was able. He did graduate work in medicine at Tulane and in New York. He was a Mason and a Shriner. He was a member of the Methodist Church of Zebulon and served on the Official Board of Stewards for over 25 years. He was a member of the Pike County Board of Education for over 25 years and in this capacity assisted and promoted better schools.

He was interested in farming and had over 1,100 acres in cultivation for a number of years. He was a captain in the Medical Corps of the U.S.A. for about a year during World War I. He was a charter member of the Pike County Lions' Club and remained a member until his death ten years later.

He was a member of the Upson County Medical Society, Spalding County Medical Society, Southern Medical Association, Medical Association of Georgia, and the American Medical Association. He was a physi-

cian and surgeon for the Southern Railway for over 50 years. He served as Mayor of Zebulon for over 12 years and was on the Board of Commissioners of Pike County for a number of years. He was on the Board of Directors of the Bank of Zebulon for over 30 years.

Although Dr. Head was forced to limit his practice in his later years, he was known to go to his fellow man in distress day or night, regardless of race, color or creed, in order to render any possible service. He was loved and admired by all who knew him.

Dr. Head's survivors include the following: Mrs. Marvin M. Head, wife, of Zebulon, Georgia; Mr. Marvin Nicholson Head, son, Zebulon, Georgia; Dr. Douglas L. Head, Sr., brother, Zebulon, Georgia, who graduated from Medical School in 1919 and joined him in Zebulon, Georgia; Mr. H. W. Head, brother, Anderson, Georgia drug salesman for over 43 years, and Miss Lutie Pope Head, sister, Zebulon, Georgia. Dr. Marvin Head was preceded in death by his brother who resided in Phoenix City, Arizona. All of Dr. Head's brothers were influenced to serve their fellow men by his example.

The Spalding County Medical Society, his fellow practitioners, and all who knew Dr. Marvin M. Head will miss him and his influence.

THEREFORE, BE IT RESOLVED that the Spalding County Medical Society placed these notes in its minutes commending him for his long years of dedicated service to this area.

AND BE IT FURTHER RESOLVED that a copy of these resolutions be sent to his beloved wife, his son, the Medical Association of Georgia, the American Medical Association, and the Pike County Journal.

George Henry, M.D.

H. A. Foster, M.D.

Honorable Ernest Vandiver
Governor of the State of Georgia
Atlanta 3, Georgia

Re: Final Report of the Medical Association of
Georgia Committee Appointed at Your Request
to Study Milledgeville State Hospital

Dear Governor Vandiver:

We take pleasure in handing you with this letter our Final Report (with Exhibits and Transcript of Testimony) after our study of Milledgeville State Hospital.

As you know, the Committee members have been pleased to serve without compensation and have borne their own expenses. The Committee is authorized by the Council of the Medical Association of Georgia to say that the Association is assuming the other expenses of the study, legal fees and expenses, court reporter's bill, and the like. The doctors of Georgia, therefore, take pleasure in making this Report to you free of cost to the State.

As you will see in the Report, our recommendations will mean additional duties and work for you and others. To the extent that we five members of the Association can commit it, we pledge the active and vigorous work and support of the Medical Association of Georgia for the program you will institute for the better care and treatment of the mentally ill in Georgia in the coming years.

This Committee has worked in a mood of enthusiasm and optimism. We are glad of the opportunity afforded us to be a part of the present events which we genuinely believe will make the year 1959 historic in the annals of medicine and psychiatry in the State of Georgia.

Respectfully yours,

W. Bruce Schaefer

W. BRUCE SCHAEFER, M.D.
Chairman, M.A.G. Committee Appointed
at the Request of the Governor to
Study Milledgeville State Hospital

REPORT of MAG Milledgeville Study Committee

W. Bruce Schaefer, M.D., *Chairman*

John A. Bell, Jr., M.D.

Rives Chalmers, M.D.

Corbett H. Thigpen, M.D.

R. Hugh Wood, M.D.

INTRODUCTION

THIS COMMITTEE was appointed by the President of the Medical Association of Georgia on March 8, 1959, at the request of the Governor of Georgia. The Committee organized at Athens on March 13, 1959. It has met in Milledgeville on March 15, March 18, and April 7, and in Atlanta on March 27 and April 19.

The Committee, while investigating specific charges as to the qualifications and practices of Staff members at the Milledgeville State Hospital, approached its duties on the basis that it could best serve the Governor and State not just as a fact-finding body but also as a study group to develop general recommendations with reference to the administration and professional staffing of the Hospital.

The Medical Association of Georgia is deeply aware that there are 11,970 persons suffering with mental illness who are presently committed to the care of the State and confined at the Milledgeville State Hospital. This Committee of the Medical Association of Georgia has kept before it as its primary concern those persons and the persons in our state who will be committed to mental hospitals in the future.

This Committee's study of the Milledgeville State Hospital has been preceded by at least twelve other studies or investigations since 1913. General recommendations based on this present study have been made before and, in many cases, several times. A short review of the previous studies of Milledgeville State Hospital follows:

In 1913, Dr. Y. H. Yarbrough, now Senior Consulting Psychiatrist at Milledgeville State Hospital, delivered an address at a meeting of the Medical Association of Georgia in Savannah. The address was printed under the title, "A Plea for Psychopathic Wards and Hospitals" (1913 *Journal of the Medical Association of Georgia*, page 109). In that article, Dr. Yarbrough made a plea for a change in the public attitude toward mental illness, for better and more complete staffing of the mental hospitals in Georgia, and for the establishment of psychopathic wards and hospitals in the major population centers of the State. The Committee finds it striking that 46 years later it is independently making much the same set of recommendations which in turn were repeated in part in 1916, 1919, 1921,

1926, 1938, 1943, 1945, 1952, 1954, 1956 and 1958.

In 1916, the recommendation was for an additional mental hospital near Atlanta. In 1919, mental clinics throughout the State were recommended. In 1921, a study called for a separate "colony for epileptics and imbeciles". In 1926, the need for a mental hospital near Atlanta and an epileptic colony were re-emphasized.

In 1938, a study called for more personnel, better administration, more medical work, and a great increase in measures of treatment at Milledgeville. That study also urged better laws and three new institutions in Georgia as well as teaching hospitals at the medical schools. In 1943, improved quantity and quality of psychiatric nursing at Milledgeville were emphasized.

In 1945, a comprehensive survey by the United States Public Health Service concluded with 87 specific recommendations for improving care of the mentally ill in Georgia.

In 1952, a comprehensive study and recommendations were made by the Central Inspection Board of the American Psychiatric Association.

In 1954, the Governor's Committee on Mental Health Training and Research recommended the development of an associated faculty for training in psychiatry by coordinating the two medical schools with the Milledgeville State Hospital as well as by increasing the budget for psychiatric residents at the University of Georgia.

In 1954, 1956 and 1958, committees of the Legislature of the State of Georgia made specific recommendations, many of which had been made earlier and many of which are repeated in this study in 1959.

Many of the recommendations made in earlier years, especially as to physical facilities, have been carried out. However, the recommendations which this Committee feels to be the most essential have never been followed. The basic and vitally important points made by Dr. Yarbrough in 1913 still remain to be accomplished.

While in the following Report the Committee is detailing certain specific findings critical of policies, and in some cases, of the actions of individuals, it wishes to emphasize, in its judgment, that the Staff of Milledgeville State Hospital is loyal and devoted to the care of the patients and to improving that care at all times.

This Committee would do a grave injustice if it did not emphasize at the outset its strong appreciation for the devoted service of those who care for the mentally ill of Georgia. In doing so, the Committee endorses the following statement in 1945 from "The Mental Institutions of Georgia, A Survey Conducted by the United States Public Health Service", page 66:

"Those who have made this study would deprecate the inference on the part of anyone that loyal service and earnest endeavor to bring about what is best for the State of Georgia is unappreciated. Many fine and able persons have striven to that end."

In 1843 when Milledgeville State Hospital opened its doors to its first patient, "asylum for lunatics" was the common denomination of such institutions. This attitude toward the mentally ill persists today. Can the people of Georgia explain as permissible the anachronisms still persisting in the treatment of the mentally ill in 1959 when nearly every other State in the United States has changed its attitude? The facile statement has frequently been made to this Committee or to its members that there is nothing wrong at Milledgeville State Hospital that X million dollars will not fix.

While there will be additional costs attached to the implementation of a new concept of treatment of the mentally ill as compared to their mere custodial care, all the money in the world could be sent to Milledgeville without bringing about the improvement needed if the erroneous concept now existing continues. Improvements can come about only if the principal causes of the evils in concept are removed.

The first evil is the past lack of interest of the people of Georgia. This means that those professional staff members at Milledgeville State Hospital who take pride and want to do well with their patients have been limited by the indifference of the State, and because of that indifference, by the fortuitous control of a hard core of persons who do not understand the need for changing the basic approach to the treatment of the illness of those entrusted to the State as patients at Milledgeville State Hospital.

The second evil is the basic public feeling that there is something loathsome about mental illness and something shameful if a member of the family suffers from it. This attitude exists today even though it is factually established that nearly 70 per cent of those sufficiently mentally disturbed to be hospitalized can be restored to useful life after treatment for 90 days.

The third evil is the symptom of the two basic evils of concept described above. The direction of the care and treatment of the mentally ill is presently entrusted to a non-professional, lay person. The position of the Director of the Department of Public Welfare requires him to account to the people, not for the best treatment of the mentally ill, but for the least possible expense in the current year attributable to a problem which the people wish to put from their minds. The people of Georgia cannot expect improvement in the treatment of their mentally ill under such a system. Only a fully qualified professional man—trained for years in psychiatry and administration—can be properly entrusted to make crucial decisions of allocation of the budget. Only such a qualified psychiatrist can give the Superin-

tendents of public mental institutions that support for their programs of treatment, rather than the immediately cheapest care of the mentally ill.

To underscore its belief that the specific problems at Milledgeville State Hospital are due at least in part to the fact that professional, psychiatrically trained administration is presently lacking at the State level, this Committee quotes from the definitive findings of the Committee to Survey Kentucky's Mental Health Needs and Resources. The Kentucky Committee reported in 1955 after joint work between prominent citizens of Kentucky and the Office of the Medical Director, American Psychiatric Association, Washington, D. C. The report, at Chapter III, Page 1, states:

"A program designed to serve the needs of large numbers of people, whose problems are immediate and acute, needs strong, independent, professionally trained leadership, and adequate numbers of trained personnel.

"Because the problems are acute, and because current knowledge about treatment is well ahead of practice in most states, staffing and administering such a program require the full time of a well qualified administrator. A separate department has been found necessary by most states embarking on an expanded program. . . . Sixteen states now have a separate department, and the number is increasing.

"The department head should be fully qualified professionally, and should have cabinet rank. He should have direct access to and enjoy the confidence of the Governor. He should not be subject to change on political grounds. He should be regarded as the professional head of a medical program, aloof from partisan politics, but able to gain the support of the people for a sound progressive program—perhaps the highest form of politics in a democratic state."

The Committee is aware that its work was prompted after considerable publicity had been given to conditions at Milledgeville State Hospital. It believes that the people of Georgia have been aroused and are interested and willing to take the steps necessary to do what they can for the treatment of the mentally ill of this State and that the people of Georgia in their turn will support the Governor in this regard. In its recommendations this Committee has attempted to be as practical and hard-headed as possible. It is aware that the Governor cannot appropriate additional money to the budget of Milledgeville State Hospital before the Legislature meets. However, many steps suggested in this Report or steps similar to those suggested in this Report can be taken without delay and constitute the basis for beginning immediately a long-range program for changing the basic attitude of the people of Georgia and for improving the treatment of the mentally ill in Georgia.

This Committee would like to emphasize that it is a Committee of the Medical Association of Georgia. It realizes the amount of work and responsibility it is suggesting to be assumed by the Governor and by others. To the extent that five members of the Association can speak for the Medical Association of Georgia, this Committee pledges the vigorous support and work of the Medical Association of Georgia towards the improvement of the treatment of the mentally ill in Georgia over the coming years.

I. General Findings and Recommendations

Committee's Work: The Committee has interviewed the following witnesses with whom the administration and professional staffing of the Milledgeville State Hospital were discussed: T. G. Peacock, M.D., Superintendent; Thomas B. Phinizy, M.D., Senior Physician, Psychiatry; R. W. Bradford, M.D., Assistant Superintendent; Zeb L. Burrell, Jr., M.D., Assistant Medical Director; Jones Hospital; Joe D. Combs, M.D., Clinical Director; Wallace M. Gibson, M.D., Medical Director, Jones Hospital; Stephen E. Kramer, M.D., Psychiatrist, Veterans Building; Y. H. Yarbrough, M.D., Senior Consulting Psychiatrist; Judge Alan Kemper, Director, State Department of Public Welfare. In addition, the Committee has carefully reviewed earlier studies of Milledgeville State Hospital, the experience in other States, and other written materials detailed in a bibliography attached to this Report as Exhibit A. This Committee has interviewed Dr. William Rottersman, formerly Chairman of the Kansas Advisory Commission on Institutional Management, on the experience in Kansas and elsewhere.

Findings: Based on the foregoing testimony and documents as well as extensive thought and discussion by the Committee, it makes the following findings:

(1) *The Director of Public Welfare:* The Committee finds that to a large degree, the administration of Milledgeville State Hospital has been dominated by Judge Alan Kemper. Dr. Peacock testified (Peacock, pp. 392-95) (See testimony of Dr. Combs as to hiring and firing) (Combs, pp. 223-24) that the allocation of funds within the budget has always been a matter finally decided by Judge Kemper. Dr. Peacock's testimony indicated that Judge Kemper's orientation, to a large degree, controlled the recommendations made by Dr. Peacock to Judge Kemper. The Committee finds that Dr. Peacock, during his entire term as Superintendent, has made no written request to Judge Kemper for assistance in obtaining additional funds for the program for psychiatric treatment at Milledgeville State Hospital. The Committee further finds that there has been a lax system followed in formulating the budget. Dr. Peacock testified that his recommendations were passed on to the Business Administrator of the Hospital orally and that the Business Administrator passed on such requests to Judge Kemper in whose offices the request for biennial appropriations were drawn for presentation to the Legislature.

The Committee is impressed by the consistent testimony of all witnesses that there has been an emphasis on the improvement of physical plant at Milledgeville State Hospital and also on improvement of medical and surgical care for Milledgeville State Hospital patients, staff and staff dependents. As a result, the physical plant and such medical and surgical care have been improved during the administration of Dr. Peacock and

Judge Kemper. The Committee finds that there was no similar emphasis on psychiatric care and treatment. The Committee commends Judge Kemper for the great improvement in buildings and physical facilities during his tenure.

While it is clear from the annual reports of Milledgeville State Hospital and from all sources that a staff of consultants from the surrounding towns and cities has been created in connection with medical and surgical care with a budget appropriation of some \$25,-900.00 annually devoted to such consulting physicians, there has never been an organized or active staff of consulting psychiatrists. The Committee further finds that there has been no effective use by Milledgeville State Hospital of psychiatric consultants.

The Committee finds that both Dr. Peacock and Judge Kemper have not made the fullest possible use of the funds already appropriated to the Hospital for improving psychiatric care and treatment of patients at Milledgeville State Hospital. The Committee finds that Judge Kemper, a lay person, was interested in developing good State Hospital buildings, farm, pond, and other physical facilities as well as medical and surgical care. The same degree of emphasis was not exerted to carry out repeated recommendations made to improve psychiatric care and treatment at the Hospital. While this emphasis is understandable in a lay person, the Committee believes that such emphasis should be changed for the benefit of Milledgeville State Hospital and the State of Georgia. The Committee emphasizes *as the most important recommendation of all* the need for the officer at the state level in charge of mental patients and institutions in the State of Georgia to be a qualified psychiatrist whose knowledge will more nearly enable him to understand the needs of mentally ill patients than the knowledge of a lay person, no matter how competent and well intentioned he might be.

(2) *Judge Kemper and Organizational Channels:* Approximately two and one-half years ago, Judge Kemper made use of the medical and surgical facilities of the Jones Hospital at Milledgeville State Hospital for his own personal use. Dr. Burrell testified to the Committee that Judge Kemper was the first patient at Milledgeville State Hospital to be administered the drug Orinase® in the treatment of diabetes (Burrell, p. 160, Line 4). The Committee finds that the result of Judge Kemper's making use of the medical facilities of the Jones Hospital has been a close personal relationship among Judge Kemper, Drs. Wallace M. Gibson and Zeb L. Burrell, Jr. The testimony of all three of those men indicates that Judge Kemper created a serious deviation from normal organizational relationships by giving his ear to members of the staff without going through the organizational channels. Dr. Burrell testified (Burrell, p. 157; p. 168) that Judge Kemper and Dr. Peacock were able to afford him facilities for his investigational drug program and for his medical program when he could not have obtained them otherwise. Although the Committee does not criticize Dr. Burrell for using every

Reference to the transcript of testimony are made by referring in parentheses to the name of the witnesses and the page or pages and, in appropriate instances, to line numbers. References to other exhibits do not require special comment.

means at his command to further his professional work and study for the good of the patients at Milledgeville State Hospital, the Committee must find fault in Judge Kemper's handling of such a situation.

The Committee further finds that Judge Kemper was influenced by the personal feelings of Dr. Burrell toward Dr. R. W. Bradford in making the decision not to promote Dr. R. W. Bradford, the Assistant Superintendent for many years. While there may have been adequate reasons for not promoting Dr. Bradford, it could not but seem improper to Dr. Bradford that he should learn of the appointment of Dr. Norman Pursley to be Acting Superintendent at Dr. Gibson's house after others junior to Dr. Bradford already knew of Judge Kemper's decision. Judge Kemper was very candid in his testimony to the Committee (Kemper, pp. 412-13) indicating that his decision not to promote Dr. Bradford was directly related to opinions and information given to Judge Kemper by Dr. Burrell. (See also Burrell, p. 150, Lines 17-18). The Committee finds that

many, and indeed probably most, of the problems presently existing among the staff at Milledgeville State Hospital stem from this method of communication among Judge Kemper and Drs. Burrell and Gibson. While such methods and procedures are common to the political world in which field Judge Kemper professed to the Committee to be qualified (Kemper, p. 43), they are not appropriate in a hospital for the care and treatment of the sick.

The Committee further advises that, so long as the Superintendent of Milledgeville State Hospital is subject to an officer at the state level whose principal interests and competence are not in the professional area, such methods and practices will continue at Milledgeville State Hospital. In such a climate, Milledgeville State Hospital will never be the kind of institution which the people of the State of Georgia desire and need, no matter how much money is appropriated to the Hospital.

THE COMMITTEE'S GENERAL RECOMMENDATIONS FOR IMMEDIATE ACTION

(1) It is recommended that the Governor create a Division of Mental Institutions in the State Department of Public Health.

(2) It is recommended that the Governor immediately appoint an Advisory Committee on Mental Institutions. This Committee should be comprised as follows: Two should be appointed by the Governor from a list of four physicians nominated by the Medical Association of Georgia; two to be appointed by the Governor from a list of four Board certified psychiatrists nominated by the Georgia Psychiatric Association; two to be appointed by the Governor from a list of four nominated by the Georgia Association for Mental Health; one to be appointed by the Governor from a list of two nominated by the Georgia Bar Association; one to be appointed by the Governor from a list of two nominated by the Georgia Academy of General Practice; one to be appointed by the Governor from a list of two prominent businessmen nominated by the Georgia State Chamber of Commerce; one prominent businessman to be appointed by the Governor from the State at large; ex-officio members of the Advisory Committee will be the heads of the Department of Psychiatry at Emory University and the Medical College of Georgia.

(3) It is recommended that administrative responsibility for Milledgeville State Hospital be transferred to the newly created Division of Mental Institutions in the State Department of Public Health.

(4) It is recommended that the Advisory Committee select and have authority to recommend to the Director of the Department of Public Health a board certified or board eligible psychiatrist with administrative experience for appointment as the Director of the Division of Mental Institutions in the State Department of Public Health. In the judgment of the MAG Committee, the Advisory Committee cannot obtain the services of a qualified psychiatrist with administrative ex-

perience for a salary less than \$25,000 a year or more. Therefore, the MAG Committee recommends that the position of Director of the Division of Mental Institutions in the Department of Public Health carry with it a salary with a minimum provision of \$25,000 a year.

(5) It is recommended that the Advisory Committee work with the Director of the Department of Public Health in immediately appointing a temporary Director of the Division of Mental Institutions. In the period before the appointment of the temporary Director of the Division of Mental Institutions, the Director of the Department of Public Health should be directly responsible for the Milledgeville State Hospital.

(6) This Committee appreciates the services of Dr. T. G. Peacock and the need for a person of his qualifications to be Superintendent of Milledgeville State Hospital. In kindness to Dr. Peacock's physical condition and devotion to duty, he should be retired for reasons of ill health as soon as feasible and replaced by a board certified or board eligible psychiatrist with at least three years administrative experience in a public or private psychiatric institution. He should be chosen by the Director of the Division of Mental Institutions and approved by the Advisory Committee.

(7) It is recommended that the Advisory Committee be charged with the responsibility to begin looking immediately for at least five qualified psychiatrists, the names of whom can be submitted to the Superintendent of Milledgeville State Hospital and the Director of the Division of Mental Institutions for appointment to the professional staff at Milledgeville State Hospital as soon as possible.

(8) It is recommended that the Advisory Committee establish liaison with appropriate legislative committees as soon as possible to plan further action in the immediate future, in the next year, and over the future years.

This MAG Committee has discussed and considered

various other general recommendations. It believes, however, that such recommendations are within the province of the Advisory Committee above recommended. It is believed that, by appropriate screening of the population at Milledgeville State Hospital, many patients could be found to be non-psychotic, needing only special nursing care but not psychiatric treatment. Such patients

could be cared for in institutions separate from the public mental institutions of Georgia so as to qualify for Federal assistance to the extent of some \$50.00 a month under 42 U.S.C.A., Sections 301 through 305 and Sections 1351 through 1354. Such Federal assistance could well run in excess of \$1,500,000 a year not now available under present organization.

MEDIUM-RANGE RECOMMENDATIONS

Over the next one to eight months the Advisory Committee should be charged with responsibility for implementing (and, where legislation is necessary, to confer with the proper legislative committee or committees) to remedy wrong practices found by this Committee in the following areas:

(1) *Personnel Practices:* Inequities presently exist in the administration of maintenance as to employees at Milledgeville State Hospital and in charging the employees for such maintenance. The present classifications with the State Merit System for board certified or board eligible psychiatrists result in pay which is not competitive. Action should be taken to raise the classifications of board certified or board eligible psychiatrists on the staff at Milledgeville State Hospital. The Jones Hospital, the medical and surgical division of Milledgeville State Hospital, presently cares for all employees and dependents of employees as well as patients committed to the care of Milledgeville State Hospital. The Jones Hospital should not care for anyone other than a patient of the Milledgeville State Hospital and resident employees. Voluntary prepaid medical and surgical insurance should be provided as a fringe benefit for employees with a provision for election by the employee to have his dependents covered at his cost.

(2) *Centralization:* The administration of Milledgeville State Hospital presently is centralized so that administrative responsibility for almost 12,000 patients is centered in one man. The Hospital and its clinical services should be decentralized so that no one physician has administrative responsibility for clinical services to more than 2,000 patients.

(3) *Other Matters:* Further advantages should be taken of the facilities existing in the State of Georgia for services at Milledgeville State Hospital. A consulting staff in psychiatry should be organized and activated with regular consultation to members of the psychiatric staff at Milledgeville State Hospital. Liaison with general practitioners of the State of Georgia could be established and more services obtained from them for the Hospital by establishing a policy of inviting the

general practitioners of Georgia to come to Milledgeville State Hospital one day a year to assist in the physical examinations of all patients at the hospital. A vocational rehabilitation program for patients in the Hospital should be developed in cooperation with the Division of Vocational Rehabilitation of the State Department of Education. A training program for residents in psychiatry should be established in coordination with the Medical College of Georgia and Emory University. Research at Milledgeville State Hospital should be encouraged but only under the supervision of a staff research committee as more particularly recommended later in this Report in connection with drugs and research. Public relations are an important aspect presently neglected at Milledgeville State Hospital. A department of public relations should be established. The services of lay volunteer workers should be obtained for the Hospital. An active program of psychotherapy should be instituted under the direction of a staff committee on psychotherapy. The services of a resident chaplain should be obtained in cooperation with the Georgia Council of Churches. The services of the Eugene Talmadge Memorial Hospital should be obtained along the lines of the statement forwarded to the Committee by the Medical College of Georgia attached to this Report as Exhibit B. The dissemination of information on the emergency care of psychiatric patients to general practitioners in the State of Georgia should be furthered in cooperation with the Southern Regional Education Board and the Mental Health Division of the Department of Public Health.

(4) *New State Facilities:* The State of Georgia is presently in great need of new facilities for the treatment of the mentally ill other than at Milledgeville State Hospital. The most expedient ways to obtain screening centers in major population centers around the State of Georgia should be investigated and implemented. It is recommended that funds be allocated for the establishment of State-operated screening centers for committed mental patients in association with Emory University School of Medicine and the Medical College of Georgia.

LONG-RANGE RECOMMENDATIONS

The Advisory Committee and the appropriate legislative committee or committees should, as soon as possible, give consideration to the drawing up of legislation creating a State Department of Mental Health. Such Department of Mental Health shall administer the medical and physical care and the mental rehabilitation of patients in all public institutions charged with care and treatment of mentally ill persons. The Department will be responsible for the State's entire mental health pro-

gram, including planning, program development, research, training and treatment. The Department will also be responsible for the development and maintaining of community psychiatric clinics throughout the State of Georgia.

Supervising and responsible for the Department of Mental Health shall be a Board of Mental Health of ten members similar in composition and selection to the previously described Advisory Committee.

II. *Drugs and Research*

Committee's Work: The Committee obtained the able assistance of Raymond P. Ahlquist, Ph.D., Professor and Chairman of Pharmacology, Medical College of Georgia, for expert advice on the technical aspect of investigational drug problems. Dr. Ahlquist attended the first two meetings of the Committee at Athens and Milledgeville. It requested Dr. Ahlquist to question the appropriate witnesses on the technical aspects of the investigational drug program at Milledgeville State Hospital. The following witnesses were interviewed on that subject: T. G. Peacock, M.D., Superintendent; Thomas B. Phinzy, M.D., Senior Physician, Psychiatry; R. W. Bradford, M.D., Assistant Superintendent; Zeb L. Burrell, Jr., M.D., Assistant Medical Director, Jones Hospital; George W. Taylor, Ph.G., Pharmacist; Norman Allen, Laboratory Technician, Hematology; John A. King, Chief Medical Technologist; Thomas A. Brantley, Sr., Medical Technologist; Judge Alan Kemper, Director, State Department of Public Welfare. Dr. Ahlquist examined the data sheets and other exhibits furnished by Dr. Burrell. Dr. Ahlquist further drew on his study and knowledge of the Federal Food, Drug and Cosmetic Act and scientific literature. Based on the foregoing research, Dr. Ahlquist presented to the Committee his findings on the technical and professional aspects of the investigational drug program at Milledgeville State Hospital, a copy of his "Professional Opinion Regrading the Use of Investigational Drugs by Dr. Zeb L. Burrell, Jr. at the Milledgeville State Hospital" being attached to this Report as Exhibit C.

The Committee addressed a questionnaire to those in charge of the public mental institutions of the 48 other states and the District of Columbia relative to investigational drug programs in those institutions and the kind of consent obtained from patients or their guardian or next-of-kin. The response was gratifying and very helpful to the Committee. A file of replies is attached as Exhibit D.

Through the cooperation of Judge Alan Kemper photostatic copies of front and back of each cancelled check with respect to the Medical Research Fund, as well as photostatic copies of all bank statements, were obtained and examined. Dr. Burrell, upon request, had each drug house confirm directly to the Committee the total amounts paid to him or to the Medical Research Fund. Based on a study of the cancelled checks and bank statements as well as the impartial verifications of gross amounts paid to Dr. Burrell or the Medical Research Fund, a report on the financial aspects of the investigational drug program at Milledgeville State Hospital is attached to this Report as Exhibit E.

Committee's Findings: Based on the foregoing testimony, data, and professional expert advice, the Committee finds as follows with respect to the investigational program at Milledgeville State Hospital:

(1) Dr. Zeb L. Burrell, Jr. is qualified scientifically as an expert to investigate the drugs in questions as specified in Section 505(a), Regulation 2.111 of the Food and Drug Act. The studies as carried out by Dr.

Burrell as shown by the patients' records and Dr. Burrell's publications are adequate. The investigational drugs listed below were used only in patients suffering from disorders for which the drugs are indicated.

Hydroxazine	—cardiac arrhythmias
Tolbutamide	—diabetes mellitus
Chlorpropamide	—diabetes mellitus
Metahexamide	—diabetes mellitus
Hydrochlorothiazide	—Hypertension and/or congestive failure
Myordil	—angina pectoris
Singaserp	—hypertension

There is affirmative evidence to show that Dr. Burrell was not the first physician to administer to humans any of the drugs in question. Pursuant to regulations of the Federal Food and Drug Administration, all of these drugs had been tested for toxicity and analysis on animals and humans before Dr. Burrell administered any of them to any patient at Milledgeville State Hospital. Dr. Burrell complied with regulations of the Federal Food and Drug Administration with respect to the required "Statement of Investigator Re New Drug," F.D.A. Form No. 14C-28B.

(2) It appears from the testimony that in some instances Dr. Burrell solicited decisions of the Staff at Milledgeville State Hospital with respect to the administering of particular drugs to particular patients. The Committee finds, however, that Dr. Burrell did not have any established practice or policy of obtaining the prior opinion of the staff psychiatrist in charge of the particular patient that the drug was indicated in the treatment of the condition of his particular patient. It appears that the investigating physician, Dr. Zeb L. Burrell, Jr., in most instances, assumed the responsibility for decisions to administer the drug to particular patients without obtaining consultation or advice from other physicians (Burrell, pp. 133-34; p. 147, Lines 19-24).

(3) With respect to obtaining and handling of funds granted by the drug houses to Dr. Burrell or the Medical Research Fund, the Committee finds as follows: Dr. Burrell made no attempt to conceal any disposition of those funds. Dr. Burrell made a truthful and complete report to the Committee in the form of a balance sheet handed to the Committee. Dr. Burrell did not use good judgment in handling the Medical Research Fund as he did. Dr. Burrell alone had complete control and disposition of the funds. Decisions in most instances to compensate physicians or assistants by "bonus" or "honorarium" were made by Dr. Burrell alone after the services had been furnished by the recipient.

Of approximately \$19,500.00 spent by Dr. Burrell from June, 1956, through December, 1958, only approximately \$7,500.00 was used for items relating to equipment and comfort in the laboratories. Approximately \$12,000.00 was used for personal payments to Dr. Burrell, the salary of Mrs. Burrell, and for entertainment of and payments to others in amounts determined by Dr. Burrell. He compensated doctors of surrounding towns on a consulting basis by grants after the

services had been rendered. Less than \$5,000.00 was spent for items directly made necessary by the research: i.e. film and film processing, teaching materials, laboratory services, equipment, and supplies. The Committee, therefore, finds that Dr. Burrell used the funds from the drug houses for the large part in ways which increased and emphasized his personal power with employees and associates at the hospital. The more normal arrangement in an institution such as Milledgeville State Hospital would provide that no one man be given the power in his sole discretion to disburse such a considerable sum of money to staff or other persons or to the comfort of such persons.

(4) The Committee finds that Milledgeville State Hospital obtained with respect to each patient admitted to the hospital, and therefore, with respect to each patient to whom investigational drugs were administered, a blanket consent to "any recognized psychiatric treatment" indicated for the improvement of the condition of each patient. The Committee distributed questionnaires concerning the form of consent obtained by public mental institutions in 48 other States and the District of Columbia. A file containing the answers to such questionnaires is attached as Exhibit D. Thirty-seven states replied to the questionnaire. Of those states, 32 administered investigational drugs, 32 states administered drugs only in the treatment of psychiatric illness, and 14 states administered them, as at Milledgeville State Hospital, for the treatment of physical illness of mental patients. Of the 32 states having an investigational drug program, only seven required consent of guardian or next-of-kin or committing authority with respect to each individual investigational drug to be administered to a particular patient. The balance of states, 25 in number, considered either the original blanket consent or, where appropriate, consent of patient, or the normal implied consent to any recognized treatment for physical or mental ills upon entry to a public institution sufficient. It will be observed from the attached Exhibit D that some states make a differentiation between investigational drugs administered after a staff decision that the drug is indicated in the treatment of a disorder of the particular patient from cases where drugs are developed in the laboratories of the particular institution which have not been previously tested for toxicity and analysis on animals and humans.

(5) The Committee finds that the March 5, 1959, Directive of the Governor, now in force with respect to Milledgeville State Hospital, restricts the investigational drug program. The Committee finds that the optimum treatment of patients at Milledgeville State Hospital requires the use of investigational drugs pursuant to the Regulations of the Federal Food and Drug Administration before being placed upon the F.D.A. list in cases where staff decisions have been made that the drug is indicated for the treatment of the particular patient.

The Committee recommends:

That the Governor's Directive be modified to require as follows:

(1) That no drug be administered to a patient at Milledgeville State Hospital without the consent of the patient, where appropriate, or of the guardian or next-of-kin of the patient where personal consent cannot be obtained, unless the drug previously has been tested

for toxicity and analysis on animals and humans.

(2) That drugs which have been tested for toxicity and analysis on animals and humans may be administered to patients at Milledgeville State Hospital pursuant to the Regulations of the Federal Food and Drug Administration after a staff decision with respect to each drug and each patient as recommended below:

(a) A research committee of five physicians on the staff of Milledgeville State Hospital, elected by the Staff, with the Superintendent of the Hospital serving ex officio as chairman of that research committee, be set up:

(i) To decide as to the initiation of each investigative drug program;

(ii) To give orders for disbursing funds received from drug houses in connection with the investigational drug program at Milledgeville State Hospital. Additional compensation should not be paid full-time employees of the State of Georgia unless the principle and method of payment are approved by a ruling of the Attorney General of the State of Georgia.

(b) The office of Director of Research should be established. The Superintendent should appoint the Director of Research who will be advised by, and who will advise with, the Research Committee mentioned in paragraph (a) above with respect to the general administration of the investigational drug program at Milledgeville State Hospital.

(c) Before administering an investigative drug to any patient at Milledgeville State Hospital, the decision to administer the drug should be made, except in emergency, by two staff members, one of whom is the clinical psychiatrist in charge of the particular patient. An affirmative finding should be entered in writing that the particular drug is indicated for treatment of the patient's physical or mental condition.

(d) Funds received from drug houses should be paid to and handled through the Hospital Accounting Department on order of the Research Committee mentioned in paragraph (a) above. Decisions to compensate personnel for work in the investigative drug program should be cleared with the Attorney General as to principle and method in advance and the decisions made before the services for which compensation is authorized are performed.

(e) Investigational drugs should be administered only to patients as to whom the standard consent to treatment is obtained on the admission of that patient. If drugs should be developed at Milledgeville State Hospital and such drugs have not been tested elsewhere for toxicity and analysis on animals and humans, individual consent from the patient where appropriate or, where not appropriate, from the patient's guardian or next-of-kin, should be obtained as to each particular drug.

(3) That the Director of Research and Research Committee adopt the procedures and forms of consent used by the Division of Mental Health, Nebraska Board of Control of State Institutes. (A part of Exhibit D).

(4) The Committee strongly recommends that programs of research, such as investigational drug programs, be encouraged in the future. It is most important to give the best care and treatment to patients at Milledgeville State Hospital. To attain this vital emphasis it is necessary and wise to encourage research not only to afford the best treatment at the time to the patient, but to attract the best candidates for training in medicine and psychiatry.

III. *Drug and Alcoholic Addiction of Staff*

A. ADDICTION AMONG PRESENT STAFF

Committee's Work: The Committee interviewed the following witnesses on this subject: T. G. Peacock, M.D., Superintendent; Thomas B. Phinizy, M.D., Senior Physician, Psychiatry; R. W. Bradford, M.D., Assistant Superintendent; Zeb L. Burrell, Jr., M.D., Assistant Medical Director, Jones Hospital; Georgia W. Taylor, Ph.G., Pharmacist; Joe D. Combs, M.D., Clinical Director; Wallace M. Gibson, M.D., Medical Director, Jones Hospital; Stephen E. Kramer, M.D., Psychiatrist, Veterans Building; Y. H. Yarbrough, M.D., Senior Consulting Psychiatrist; Judge Alan Kemper, Director, State Department of Public Welfare.

Committee's Findings: Based on the foregoing testimony, the Committee finds as follows:

(1) Dr. Peacock testified (Peacock, pp. 402-03) that he himself, before coming to Milledgeville State Hospital, had a problem with alcohol. Dr. Peacock said that he had not had any alcoholic or drug problems while at Milledgeville State Hospital. There was positive testimony that Dr. Peacock had made no executive decisions concerning Milledgeville State Hospital while under the influence of drugs (Burrell, p. 142; see also Bradford, p. 60, LL-4-6; Peacock, p. 402, LL 24-25). Based on the foregoing, the Committee finds that Dr. Peacock had a previous problem with alcohol. However, the Committee finds no evidence that Dr. Peacock has made executive decisions concerning Milledgeville State Hospital while under the influence of alcohol or drugs. The Committee finds that the physical condition of Dr. Peacock is such that, in kindness to him and to his devotion to his duty, he should be relieved from active duty as Superintendent of the Hospital as soon as the appointment of a qualified psychiatrist with experience in administration to serve as Superintendent can be obtained.

(2) The Committee finds that one physician, previously on the staff, was addicted to alcohol. The Committee finds that he was under the influence of alcohol while on duty and that his connection with the Hospital was terminated on March 14, 1959. (Combs, pp. 217-18; Peacock, p. 402).

(3) The Committee finds that one staff member has been hospitalized because of problems of this kind, but the Committee has heard no direct evidence that he was under the influence of either alcohol or drugs while on duty. The Committee has heard no direct evidence of any other abuses on duty.

(4) The Committee finds that six staff members have previous histories of addiction to drugs or alcohol but has heard no evidence of present addiction.

B. EMPLOYMENT

Committee's Work: The Committee interviewed the witnesses named under "Committee's Work" in the previous section of this Report with respect to the employment policy in cases of drugs and alcoholic addiction.

Committee's Findings: Based on the foregoing testimony, the Committee finds as follows:

(1) Judge Kemper and Dr. Peacock have definitely followed a policy of looking for doctors having problems with alcohol and drugs as possible members of the staff at Milledgeville State Hospital. Judge Kemper was explicit in saying that he had from time to time heard that some doctor was in trouble with drugs or alcohol and in each instance he had advised Dr. Peacock of the name and address of such persons. (Kemper, p. 421). There does not appear to be any dispute of fact concerning this policy. Dr. Peacock testified that he checked with previous employers of applicants for staff positions by telephone but that he did not make any written memoranda of the conversations with previous employers (Peacock, p. 400, p. 403).

(2) The Committee further finds that physicians with histories of addiction to drugs or alcohol have been hired when only partially rehabilitated (Peacock, p. 19, Lines 7-8). Dr. Peacock explained that he could continue the rehabilitation and use of such men while on the staff.

(3) The Committee finds that the policy of searching out physicians having problems with alcohol or drugs with the thought of making them members of the Staff of Milledgeville State Hospital before complete rehabilitation is unwise. On the other hand, the Committee finds and advises that it would not be improper for the Superintendent of Milledgeville State Hospital to employ a physician who has a past history of addiction to a drug or alcohol but who is considered completely rehabilitated. It is assumed, of course, that such candidate for physician on the staff is professionally qualified for the position designated.

Committee's Recommendations:

(1) The Committee recommends that the employment of members of the professional staff of Milledgeville State Hospital be left to the discretion of the Superintendent. It is further recommended that the Superintendent be given authority to employ those he thinks best qualified for positions considering all of the facts at his disposal. It is further recommended that the Superintendent make a thorough study of all applicants for positions on the professional staff and create a written file concerning such applicants. The Committee recommends that the Superintendent not hire any physicians having a history of addiction to do staff work unless the Superintendent is reasonably certain that the physician is definitely rehabilitated. Further, it is recommended that the Superintendent allow no abuses on duty with either alcohol or drugs and that any physician who is under the influence on duty should be either discharged or treated as a patient and not continued on the active staff while he has any problems with drugs or alcohol.

IV. *Neglect of Patients*

Committee's Work: The Committee has interviewed the following witnesses with respect to the neglect of patients in the Jones Hospital, both as to the scheduling of surgery, and as to the follow-up after surgery has been performed: T. G. Peacock, M.D., Superintendent; Thomas B. Phinizy, M.D., Senior Physician, Psychiatry; R. W. Bradford, M.D., Assistant Superintendent; Zeb L. Burrell, Jr., M.D., Assistant Medical Director, Jones Hospital; Joe D. Combs, M.D., Clinical Director; Wallace M. Gibson, M.D., Medical Director, Jones Hospital; Mrs. Myra Bonner, R.N., Superintendent of Nurses; Stephen E. Kramer, M.D., Psychiatrist, Veterans Building; Y. H. Yarbrough, M.D., Senior Consulting Psychiatrist.

Committee's Findings: Based on the foregoing testimony, the Committee finds as follows:

(1) Emergency operations have been scheduled and performed as required.

(2) There have been great strides made in recent years in scheduling and performing elective surgery. Because of the crowded conditions of Milledgeville State Hospital and the fact that the Hospital provides, as a fringe benefit to employees, medical and surgical service to them and their dependents free of charge or for a nominal charge, some elective surgery has been delayed. Forty to 50 per cent of beds and time at the Jones Hospital is taken up by treatment of employees and employees' dependents (Burrell, p. 173, Lines 13-17; Gibson, pp. 269-70). In the case of two patients of Dr. Thomas Phinizy, delay in elective surgery resulted in some discomfort to the patients. In these two cases the Committee finds that delay in

scheduling resulted in part from poor professional communication between Dr. Phinizy and the Jones Hospital.

Committee's Recommendations:

(1) Any actual delays in the scheduling of elective surgery of patients of Milledgeville State Hospital should be remedied, consistent with the facilities and the number of patients.

(2) The Committee recommends that all employees of Milledgeville State Hospital be provided voluntary prepaid insurance for medical and surgical care, paid for by the State, with employees allowed to elect, and pay for, coverage for their dependents. It realizes that the Jones Hospital has had under its care not only the nearly 12,000 patients duly admitted to the Milledgeville State Hospital but also 2,200 employees and from 6,000 to 8,000 employees' dependents (Gibson, pp. 269-70). The provision of insurance coverage for employees and their dependents would afford them a free choice of physician in Milledgeville or in other towns and thereby relieve the pressure on the Jones Hospital. No one other than mental patients and resident employees should be treated at the Jones Hospital except as an emergency. The Committee believes that the providing of such insurance coverage will afford employees sufficient fringe benefit in this area at an ultimate economy to the State of Georgia.

(3) If it should be determined that the State cannot subsidize such a medical and surgical program of insurance without legislation, such legislation should be introduced at the next session of the Legislature. In the meantime, such coverage should be afforded with the employees paying the premiums.

V. *Dr. Gibson*

Committee's Work: With respect to Dr. Wallace Gibson's use of instruments from the operating room and Dr. Gibson's surgery at other institutions, the Committee has interviewed the following witnesses: T. G. Peacock, M.D., Superintendent; Thomas B. Phinizy, M.D., Senior Physician, Psychiatry; R. W. Bradford, M.D., Assistant Superintendent; Zeb L. Burrell, Jr., M.D., Assistant Medical Director, Jones Hospital; Mr. Buford Quinn, Technician, Operating Room; Mrs. Marion Garland, R.N., Supervisor of Nurses of the Operating Room; Wallace M. Gibson, M.D., Medical Director, Jones Hospital; George Escamilla, M.D., Jones Hospital; Mrs. Ruby Hood, R.N., Operating Room; Mrs. Violet Tidwell, R.N., Operating Room; S. R. Smith, M.D., Anesthesiologist; Mrs. Marie Vincent, R.N., Operating Room; Judge Alan Kemper, Director, State Department of Public Welfare. In addition, individual members of the Committee have examined Dr. Gibson's income tax returns to the State of Georgia and the United States for the years 1957 and 1958;

interviewed Dr. Sanchez of the Eatonton Hospital Staff; and interviewed Dr. Robbins of Vidalia.

Committee's Findings: Based on the foregoing testimony and documentary evidence, the Committee makes the following findings:

(1) Dr. Gibson has temporarily removed instruments from the operating room of the Jones Hospital for use in operations at private hospitals. Some of the instruments used by Dr. Gibson were owned by him personally and not by Milledgeville State Hospital. There is no evidence that any patient has suffered by reason of the above mentioned removal of instruments from Milledgeville State Hospital.

(2) The Committee finds that Dr. Gibson has done surgery at private institutions in Eatonton, Milledgeville, and Vidalia. The Committee has neither heard nor seen any direct evidence that he was compensated with his knowledge for any such services. The Committee has neither heard nor seen any direct evidence that Mrs. Gibson was compensated for Dr. Gibson's services at private institutions.

Committee's Recommendations

(1) The State of Georgia should purchase and own all instruments necessary for surgery in the Jones Hospital. No surgical instruments belonging to the State of Georgia should be removed from the Jones Hospital.

(2) The Committee recommends the policy that full time members of the Milledgeville State Hospital should

not render services outside of the Hospital. The Committee recognizes that certain exceptions to the foregoing may justifiably occur in emergencies and where members of the staff of Milledgeville State Hospital are consulted by physicians in the surrounding municipalities. The Committee recognizes the present exception to this policy in the case of the radiologist.

VI. Surgery by Nurses

Committee's Work: The Committee interviewed the following witnesses at Milledgeville on March 15, March 18 and April 7, 1959, concerning the performance by nurses of surgical procedures: T. G. Peacock, M.D., Superintendent; Thomas B. Phinzy, M.D., Senior Physician, Psychiatry; R. W. Bradford, M.D., Assistant Superintendent; Zeb L. Burrell, Jr., M.D., Assistant Medical Director, Jones Hospital; Buford Quinn, Technician, Operating Room; Mrs. Marion Garland, R.N., Supervisor of Nurses of the Operating Room; Joe D. Combs, M.D., Clinical Director; Wallace M. Gibson, M.D., Medical Director, Jones Hospital; George Escamilla, M.D., Surgeon, Jones Hospital; Mrs. Myra S. Bonner, R.N., Supervisor of Nurses; Mrs. Ruth B. Hood, R.N., Operating Room; Mrs. Violet Tidwell, R.N., Operating Room; S. R. Smith, M.D., Anesthesiologist; Mr. John A. King, Chief Medical Technologist; Mrs. Tommie Berry, Baldwin County Nurses Association; Mrs. Marie Vincent, R.N., Operating Room; Oris H. Strickland, Technician, Operating Room; Miss Joyce Smith, R.N., Operating Room; Thomas A. Brantley, Sr., Medical Technologist; Judge Alan Kemper, Director, State Department of Public Welfare; Dr. James E. Baugh, Milledgeville; Mrs. Jacqueline Watson, R.N., Milledgeville, formerly Nurse, Operating Room; Mrs. Buford Quinn, Technician, Laboratory; Mrs. R. A. Broome, R.N., Jones Hospital; William R. Crittenden, Acting Institutional Business Administrator.

Comment: The Committee, on the first day of taking testimony at Milledgeville on March 15, 1959, was confronted with a direct conflict of testimony with respect to the issue of whether any nurses or nurses had performed surgical procedures beyond the proper scope of duties of a First Assistant to the Surgeon. It returned to Milledgeville on March 18, 1959, and again on April 7, 1959, to take further testimony on this issue. After all of the testimony was taken, the posture of the evidence was as follows: Four witnesses testified positively that they had been present and witnessed Mrs. Marion Garland, R.N., Supervisor of Nurses of the Operating Room, Jones Hospital, perform various procedures beyond the proper scope of duties of a First Assistant. All four of such witnesses testified to witnessing the performance of vasectomies by Mrs. Garland while a similar operation on another patient was being performed by a surgeon in the same room. All four witnesses testified that they had witnessed Mrs. Garland doing such operations both under the direct supervision of a doctor and not under the direct supervision of a doctor. Two of the four witnesses testified positively to having witnessed Mrs. Garland perform vasectomies, salpingectomies and hip-nailing, when no doctor was present in the operating room. One witness testi-

fied to the performance by Mrs. Garland of appendectomies with no doctor present. Three of the four witnesses also testified that they had witnessed Mrs. Garland administering spinal anesthesia when a doctor was present in the operating room and two when a doctor was not present in the operating room.

On the other hand, Dr. Gibson and Mrs. Garland denied all of the above testimony categorically. Those among the present employees of the operating room interviewed by the Committee denied ever having witnessed any such surgical procedure by Mrs. Garland.

All witnesses testifying on this issue on March 18, 1959, and on April 7, 1959, were asked, as a voluntary matter, whether they would give their testimony under oath. All witnesses on those days did take the oath as a voluntary matter.

The Committee examined the witnesses at length on collateral issues, principally on the events occurring on the night of March 6, 1959, the night on which the issue of *The Atlanta Constitution* first appeared carrying the charge that a nurse at the Jones Hospital had performed surgery. After lengthy questioning concerning the events of that night, it began to appear to the Committee that Dr. Gibson, Mrs. Garland and the present members of the staff of the operating room were giving a similar story of the events of that night. This began to appear to be a pre-arranged story. Certain inconsistencies on smaller facts about that night were detected. The Committee felt that it was necessary to pursue this collateral issue to the ultimate truth.

On April 7, 1959, it became apparent to the Committee by incontrovertible and credible testimony and documentary evidence that Dr. Wallace Gibson had falsified his testimony concerning the events of the night of March 6, 1959. Dr. Gibson was confronted with this evidence and did not deny the falsification.

Committee's Findings: Based on the foregoing testimony and documentary evidence, the Committee makes the following findings:

(1) The Committee believes the testimony of the four eye witnesses who testified to the performance by Nurse Garland of surgical procedures beyond the scope of duty of a First Assistant to a Surgeon.

(2) The Committee finds that Dr. Wallace Gibson falsified evidence given to it on a collateral issue.

Committee's Recommendation: While the Committee appreciates the hard work over the years of Dr. Wallace Gibson in developing the medical and surgical services at the Jones Hospital, the Committee, because of the findings it has had to make, recommends that he be relieved of administrative responsibility for the Jones Building.

Professional Opinion Regarding the Use of Investigational Drugs at Milledgeville Hospital

On the basis of testimony presented at Milledgeville State Hospital on Sunday, March 15, 1959 and on my study of the exhibits furnished by Dr. Burrell and on my study and knowledge of the Federal, Food, Drug and Cosmetic Act and the scientific literature, it is my opinion that:

1. Dr. Burrell is qualified scientifically as an expert to investigate these drugs as specified in *Section 505(a), Regulation 130.3* of the Food and Drug Act.

2. The studies as carried out by Dr. Burrell as shown by the patients' records and Dr. Burrell's publication are adequate.

3. The investigational drugs listed below were used only in patients suffering from the disorders for which the drugs are indicated.

Hydroxazine—cardiac arrhythmias

Tolbutamide—diabetes mellitus

Chlorpropamide—diabetes mellitus

Metahexamide—diabetes mellitus

Hydrochlorothiazide—hypertension and/or congestive failure

Myordil—angina pectoris

Singaserp—hypertension

4. There is direct evidence that Dr. Burrell was not the first person to administer any of these drugs to humans. The dates given in the attached letter from Dr. Burrell show that he first received data sheets regarding these drugs, then at a still later date first administered the drugs. In every case the data sheets describe the use of these drugs in humans, indicating the first administration to humans has been done by others before Dr. Burrell even obtained the drugs. Even though

Dr. Burrell cannot now furnish the dates for chlorpropamide, it is my positive belief, based on my personal knowledge of this class of drugs, that he was not the first to administer it to humans.

It is also my opinion that Dr. Burrell furnished full reports of his investigations to the various manufacturers as required by law. I have, however, no direct evidence that this is true. I presume it to be true since the manufacturers continued funds to support the research.

It is also my opinion that Dr. Burrell used poor judgment in personally handling funds furnished by the manufacturer. It is my belief that, although the expenditures could have been justified, an accounting through the recognized business office of the Hospital should have been followed.

Finally, it is my opinion that because of the nature of the investigational drugs a special consent from the patient or next-of-kin for each drug need not be obtained when these drugs are used in a general type hospital such as the Eugene Talmadge Memorial Hospital. At Milledgeville State Hospital the usual permission for any recognized psychiatric treatment is probably not adequate to cover these particular kinds of investigational drugs. This permission would, however, cover the investigational use of drugs for psychiatric purposes. In any event, the express approval of the Administrator of the Milledgeville State Hospital should have been obtained.

R. P. Ahlquist, Ph. D., Professor & Chairman, Department of Pharmacology, Medical College of Georgia.

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STATEMENT BY GOVERNOR VANDIVER REGARDING MILLEDGEVILLE STUDY COMMITTEE REPORT

April 24, 1959

I HAVE TODAY CONFERRED with Judge Alan Kemper, Director of the State Department of Public Welfare and Dr. T. F. Sellers, Director of the State Department of Public Health, relative to the report handed me yesterday by the Medical Association of Georgia Committee appointed by the President of the Association at my request to study Milledgeville State Hospital and to make recommendations regarding the care and treatment for the mentally ill in Georgia.

Permit me to say first that after reading and studying this report it is one of the finest, most authoritative and all-inclusive public documents I have ever read.

Members of the medical profession who constituted the committee, the general counsel for the committee and the staff of the Medical Association of Georgia are due the highest praise for the workman-like job which they have done on it without any cost whatsoever to the taxpayers.

The report of this committee forms a worthwhile chart for future progress in the mental health field.

It contains recommendations for immediate action, for a medium-range action and for long-range action.

The Vandiver administration will move immediately to implement the provisions of this report. Appropriate Executive and Administrative Orders are being prepared to effectuate those recommendations which are susceptible of immediate action.

The first step, of course, in implementing the recommendations will be the transfer of administrative control of Milledgeville State Hospital from the State Welfare Department to the State Health Department. Judge Alan Kemper, Dr. T. F. Sellers, and myself have agreed jointly upon effectuating this transfer and Judge Kemper has expressed to me his full agreement that in view of the situation at the hospital existent among professional personnel and that it is mandatory it be transferred to the State Health Department.

As Governor, and personally, I want to express to Judge Kemper appreciation of the people of the State of Georgia for the dedicated service he has rendered Milledgeville State Hospital and other institutions under

the supervision and control of the State Welfare Department during his long tenure as its Director. Judge Kemper has served in this office practically as long as all other Welfare Directors combined. This is an excellent record of which he may well be proud.

It is my view that the proposals contained in the report for a medium-range action and for long-range action afford a worthwhile and authoritative guide for improved mental health in Georgia. I am asking Dr. Sellers to see to it that this report is implemented as soon as administratively possible and as soon as proper funds can be obtained to finance it.

The long-range phases of the report addresses itself to the Economy and Reorganization Commission.

During the past day or two there has been speculation in the newspapers relative to the Superintendent's position at the Milledgeville State Hospital. No one has been hired for this position and that addresses itself to those assuming administrative control.

It should be emphasized that the report of the MAG Committee to me proposes the appointment of an advisory committee on mental institutions composed of ten members appointed by the Governor from a list of persons submitted by various public and professional associations in the State of Georgia. An appropriate Executive Order is in the process of preparation for the establishment of this committee and when the suggested organizations make recommendations to me, members of this committee will be appointed.

The safeguards recommended by the Committee to be instituted governing administration of investigational drugs has my full support and endorsement. I am asking Dr. Sellers that the temporary safeguards placed on this program by me several weeks ago be modified as recommended.

I am in general agreement with most all of the recommendations made in the report and will support their implementation.

I have every confidence in Dr. Sellers and in the State Health Department to assume this new responsibility and to carry it forward effectively. In this, I pledge my full support.

COMMITTEE MEMBERS ON "PRESS GALLERY"



NEWSMEN INTERVIEW COMMITTEE MEMBERS—Dr. Rives Chalmers, left, and Dr. R. Hugh Wood, members of the Medical Association of Georgia Committee to study Milledgeville State Hospital, are interviewed by Editor Ralph McGill of *The Atlanta Constitution*, center, editorial writer George Boswell and Reporter Jack Nelson on WSB-TV's "Press Gallery." The program was sponsored by *The Atlanta Constitution*.

A PLEA FOR PSYCOPATHIC WARDS AND HOSPITALS

This article, originally published in 1913, reprinted here, because of its timeliness in the current controversy over Milledgeville State Hospital.

Y. H. Yarbrough, M.D., Milledgeville

THE DAWN OF CLASSICAL PSYCHIATRY dates back to a comparatively short period. The past history of psychiatry up to the Middle Ages, is known as the era of a demonical exorcism. From this period up to the 18th century is known as the chain and dungeon era; then follows that of the special asylums and hospitals, which continues to the present time with graduations of improvement to meet the existing conditions of scientific advancement. The stagnant stage of psychiatry remained undisturbed for so long on account of such superstition, that insanity is a possession of the devil, a disease of the soul; the etiology of such misfortune was unrighteousness, and the treatment was such that came through the heroic exorcism of the priest. Now our conception of mental diseases has become much clearer and our thoughts are of the disease idea of insanity and the proper way of its prevention and treatment. In contrast to the horrible consequences suffered during these dark ages we now regard these unfortunates as the most pitiable of our kind and entitled to every care and consideration that a civilized and sympathetic people can possibly extend.

The result of the treatment of mental diseases was practically about the same in all institutions until about 1880, when in Scotland there was adopted a plan of establishment in connection with general hospitals—special wards for the treatment of the recent acute and physically sick cases among the insane of the larger institutions. This plan has gradually grown in perfection and popularity until now its good results are gratifying, and while its adoption is not very extensive, its needs are quite evident. Equally as much scepticism is entertained now relative to the prognosis of the chronic insane as even in ancient times, but we realize for a favorable prognosis, the necessity of the early recognition and proper treatment of certain types of mental derangements. The existing conditions under which most of the state hospitals are operated, do not conform to this plan; but one of the most hopeful features of psychiatric outlook is the adoption of special psychopathic hospitals; and psychopathic wards, not only in connection with state institutions, but independent in cities and in connection with the general hospitals. We understand the nature of mental diseases as never before and the existence of such places as these we are considering, appear to be the most logical channels through which the opportunity for its scientific investigation and advancement is to come.

The treatment now of most of the psychoses is merely custodial, but there are a number of forms of insanity where immediate, careful, and scientific treatment aids in recovery and lessens unfavorable symptoms

which may arise in the course of the chronic types. The transfer of patients from prisons and from homes to institutions where the advanced methods of caring for them are not practiced, the benefits derived are only trifling, but with the establishment of buildings and wards where every attempt is made to carry out the proper equipment of such, the results in many instances are quite encouraging. The benefits of such types of hospitals in connection with state hospitals will not merely be limited to scientific research into causes, treatment, and results, or as a center of distribution, but to the better equipment of physicians and nurses to care for its general population.

More Nurses and Attendants

In the selection of a location for a psychopathic hospital, special attention should be given to its scenic effect. The buildings should be made as attractive as possible and everything prison-like should be omitted so far as it is absolutely compatible with safety. For a limited number of patients, however, restrictive methods may be necessary, but such should be in as remote a part of the building as possible, probably in a detached building, in order that those whose care will not necessitate such, will be spared unpleasant impressions so easily conveyed by such restrictions. Rooms should be equipped as in a general hospital; dormitories are advisable as they offer much better opportunity for closer observations; large comfortable rooms should be supplied with suitable reading matter, where patients may gather for social intercourse. The grounds should be beautified with flower beds and walks. A greatly increased number of nurses and attendants in proportion to the patients will be necessary, and these should have a high standard of qualification. The excellent opportunity offered in this way for training to nurses and attendants, is most evident and the results are invaluable, as it will be these who will afterwards have charge of its general population. Here, they will receive a practical demonstration of one of the supreme first qualifications of a good nurse—the power of accurate observation. The ever-changing movement of the ward population stimulates interest and calls forth a continuous exercise of good judgment and nursing. In charge of such wards, should be a skilled man in this line of work with a corps of assistants sufficient to permit each patient receiving a most thorough examination and close subsequent observation, as the opportunity for careful research can only come when concentration in cases is practiced. The establishment of properly equipped psychopathic hospitals in all cities, and psychopathic wards in connection with general hospitals, is most urgent. Here, voluntary commitment should be permitted, as the value of such is quite evident when we realize the number of

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cases that would seek treatment in the beginning of their troubles—should such an opportunity be afforded—and who would otherwise delay taking this necessary step, owing to the false prejudices so many entertain that a stigma is cast on those having had residence in an institution for the insane. So often sorrowed, are those to whose care these unfortunates are eventually placed, by the development of histories of moral irregularities of grave types, in those whose lives previous to the onset of their trouble had been exemplary. Usually, in the early onset there is some recognition of mental disturbance, but so well are many of the faculties preserved, and because of the delicacy of the subject, hope of early recovery, and antipathy toward the institution for the insane, cases are detained too long at home by well meaning but misguided relatives and friends, until considerable advancement has been made in their trouble. Another important feature in connection with the establishment of psychopathic wards and hospitals, is the excellent opportunity for better equipping the general practitioner in the recognition of the true nature of mental diseases, their care, and treatment. In most of our leading medical colleges, but little attention is given to the study of psychiatry, so consequently the crudeness of the average physician's knowledge regarding this branch, cannot be wondered at. Where these hospitals or wards are accessible to the medical colleges, the clinical material offered will be most valuable, in the teaching of psychiatry and thus better equip the family medical attendant in recognizing these troubles in their incipency, thereby lessening the danger of future mental status of the patient and avoiding unnecessary misery, poverty, and disgrace to the family. When these wards are in connection with the general hospitals, the opportunity for diffusing knowledge of psychiatry among the medical profession is the facilities it offers to the visiting staff. A deplorable state of affairs exists today, in our state, relative to the care of these unfortunates, previous to their commitment to the state hospitals. The sad consequences are too often seen, not only to the patients themselves, but to their families, friends, and business associates. Patients whose care would have been entrusted to these places at the proper time, continue without the necessary observation and treatment, until considerable advancement has been made in their psychoses and probably to where some

infraction on the law committed, which brings to his family humiliation, and probably to poverty, where comforts had always been enjoyed. For those of some means, and who have an appreciation of the necessity of early institutional care, we fortunately have private institutions which permit of an immediate and careful treatment, but among the class from whose rank there comes a much larger percentage of this class of patients, such an opportunity is probably denied, or its timely needs not recognized. Recognizing, then, the value of this early interference, the present law in this state, demanding ten days' notice to the three nearest adult relatives before commitment to a state sanitarium can be regarded as nothing short of criminal. The only support in favor of such a law is the protection of the defendant against an endeavor which may be exercised to gain possession of his property. Of my six years' residence in this institution (Georgia State Sanitarium), whose population is only second to any similar institution in this country, not one case has come under my observation where such a law would be applicable. In our state today in many instances, the treatment of these cases prior to their commitment is barbarous. They are placed in prison under the care of mere guards and made subject to the scrutiny of the curious and denied the tender care which they so justly deserve. Such environment tends to intensify excitement and depression and produces in indelible impression of a revolting character. Therefore, regardless of expense, ample provision, care, and best methods of treatment become a duty that the public owes to its unfortunate fellowman. Should an epidemic of typhoid fever or meningitis make its appearance all forces would be marshalled for its eradication, but silently do we stand by and watch with awe the gradual advancement of mental diseases, the saddest of all, with but little effort towards its prevention and treatment. It devolves upon the twentieth century to correct these inhuman customs, which can only be done by education.

The summary of the value of psychopathic hospitals and wards is first, the treatment of a limited number of patients; second, the opportunity for voluntary commitment; third, the proper and temporary care prior to commitment to the association among the chronic insane; and fourth, the use of the clinical material for the teaching of psychiatry.

ADVISORY COMMITTEE HOLDS FIRST MEETING

GEORGIA'S NEW ADVISORY COMMITTEE on Mental Institutions held an organizational meeting Friday, June 5 in Atlanta. Recommended by the special MAG Committee to study Milledgeville Hospital (see page 278), the Advisory Committee will work with the Governor, the Department of Public Health, legislative committees, and public organizations to formulate and effectuate plans for the care and treatment of the mentally ill of the State of Georgia.

Members of the Committee are Luther H. Wolff, MAG President, and R. Hugh Wood, former Dean of the Emory University School of Medicine, representing the Medical Association of Georgia; Rives Chalmers, Atlanta psychiatrist and a Director of the National Association for Mental Health, and William Rotters-

man, Atlanta psychiatrist and former assistant dean of the Menninger School of Psychiatry, representing the Georgia Psychiatric Association; John A. Bell, Jr., Dublin, representing the Georgia Academy of General Practice; Mr. John L. Moore Jr., Atlanta attorney with the law firm of Alston, Sibley, Miller, Spann, and Shackelford, representing the Georgia Bar Association; Mr. Peyton Hawes of Elberton and Mrs. Daisy Tucker of Columbus, representing the Georgia Association for Mental Health; Bob Rainer, D.D.S. of McDonough, appointed by the Governor from the State at large. The heads of the departments of psychiatry at Emory University and the Medical College of Georgia—Bernard Holland and E. J. McCranie—will serve as ex-officio members of the Advisory Committee.

THE MILLEDGEVILLE INVESTIGATION

As Seen by Atlanta Constitution Cartoonist Cliff Baldowski



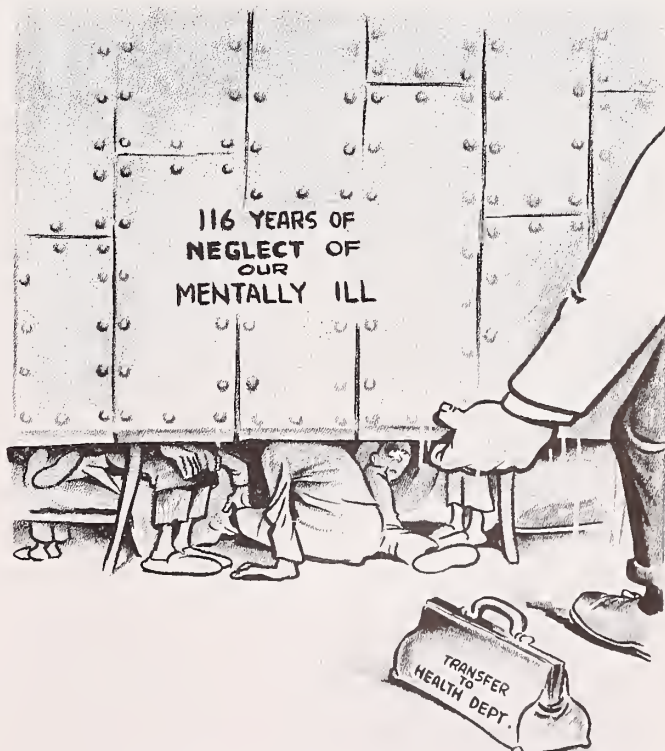
'I Don't See Anything, Do You?'



'Okay, How Far Into This Do You Wan'na Go?'



'But, Sir, We Have Plenty of Recommendations!'



Georgia Raises Its Iron Curtain

THE PHYSICIAN'S ROLE IN HOSPITALIZATION OF THE MENTALLY ILL

By the Mental Health Committee of the Medical Association of Georgia

Physician's Responsibility to the Mentally Ill Patient

The patient is the one who is sick. He is, in a sense, the symptom of distress in the family. He needs protection of his status in the family and insurance of his return to it. He also has a right to a private audience with the doctor, preferably before history is taken from the family.

Physician's Responsibility to the Patient's Family

The family is socially distressed and has extra difficulty in communication. One responsibility of ours to the family is to be direct and frank, and thus to facilitate the communication of the members of the family with each other, and with the patient. The difficulty in communication is a part of the family illness. A second responsibility of the physician to the family has to do with interpretation of the illness, of treatment, and of convalescence and return of the patient to society. A third responsibility has to do with the protection of the family unit, as well as of the individual members of it.

Physician's Responsibility to the Community

As physicians we are responsible to the community for protection: physical, moral, and criminal. A second responsibility to the community has to do with education: dispersion of ignorance, superstition, prejudice, gossip. A third responsibility to the community has to do with the return of the patient to it.

Professional Function With the Patient

Our professional function with the patient consists of an adequate history of the present illness, an estimate of the present mental status, an evaluation of the personality patterns, and a physical examination.

The history of present illness should give special attention to any organic disease or disturbance and also to the use of any medications or drugs which might influence the mental and emotional processes. It may be difficult to secure all the necessary information from the patient, but it is always important to be as thorough as possible in obtaining a history in order to obtain the patient's concept of himself in the present illness.

The mental status consists of the physician's objective appraisal of those aspects of the patient's function which reflect his perception, his thinking, and his behavior. This is usually included in the taking of history and consists in direct observation of:

- (1) Attitude and general behavior, including appearance, gait, posture, dress, etc.
- (2) Intellectual level, reflected in quickness and accuracy of perceptions, use of vocabulary, and capacity for judgment.
- (3) Sensorium, including memory, orientation, retention, and speech disturbances.

(4) Mood and emotional state, the fixity or range of the patient's feelings and affects; for example, anxiety, depression, indifference, euphoria, hostility, etc., with especial attention to any thoughts or plans for suicide.

(5) Preoccupations and special symptoms which may indicate actual delusions, hallucinations, compulsions, paranoid ideas, etc.

(6) Insight, as reflected by the verbal expression of understanding of the actual illness and also the recognition of the need for treatment and the willingness to cooperate in treatment.

Personality evaluation is derived from a historical survey of the patient's characteristic pattern in early childhood, in schooling, and in sexual, social, occupational, and other relationships. Under this heading are also noted the patient's previous maladaptations to environmental stress and frustration, to bodily disease and especially to the circumstances which precipitated and complicated the present illness. This is really a longitudinal summary of the person's responses to his own life, in order to predict his response to this present illness. This is important in planning with the family during the family conference.

Appropriate Physical Examination: A complete general physical examination including neurological, is appropriate. Most essential is examination for evidence of organic psychosis (organ diseases which give rise to mental symptoms). Organic psychoses can masquerade as functional psychoses, and vice versa. The various mental symptoms specific for organic disease are called the organic brain syndrome. This consists of confusion, impairment of orientation, memory, apperception (conceptualization), knowledge, and judgment; and instability and shallowness of affect (feeling). Diagnosis of organic psychosis is made on the basis of history, mental status examination and presence of positive neurological or other physical and laboratory findings. Some patients with organic brain syndrome are eligible for hospitalization at the State Hospital (e.g. those having psychosis associated with cerebral arteriosclerosis). Others are in more or less immediate need of treatment in a general hospital (e.g. those having psychosis associated with bromidism, brain tumor, subdural hematoma, etc.).

The general physical examination may be crucial to the diagnosis of the mental condition by revealing findings of psychosomatic disease.

In considering diagnosis and disposition, these miscellaneous observations may be helpful:

The old idea that a person is not crazy if he thinks he is, is not true. Many psychotic patients realize they are psychotic.

Patients threatening suicide or making attempts at suicide should always be considered as suicidal. The

concept that the person who threatens suicide is not likely to commit suicide has been disproven.

Neurotic patients sometimes have psychotic episodes during the course of the disease.

It is not harmful to tell a mentally ill patient that he is mentally ill—on the contrary, it may be very helpful.

Indications for hospitalization of the mentally ill fall into three general categories: need for treatment available only at a hospital; protection of self or others; and need for custodial care.

Professional Function With the Family

Once the formulation of the patient's illness and the family's information has been completed, the doctor must make a diagnosis and a prognosis for the family conference. This family conference, which may be very informal, may even resolve part of the family illness. If the doctor can get the patient and the family to plan together, even over the opposition of at least one, he will have set up a firm basis for the plans to be worked out between them and for the return of the patient to the family and community. This family plan also helps the doctor maintain his professional role and face the family with their responsibility for carrying out his recommendations. When he takes his recommendation to the family, he can advise hospital care or private psychiatric care without hospitalization. If he advises hospitalization, he can present the problems and advantages of private hospital, of state hospital, and of community general hospital with its psychiatric rooms. Some doctors use foster home placement with a member of the family who is "for" the patient or with the establishment of a formal paid foster home situation in the community. He may even suggest the development of a formal foster home placement in the community in addition to private psychiatric care. If the patient is committed, psychic trauma from the procedure can be kept at a minimum by obtaining maximum cooperation from the patient in the making of the decision, and by keeping him informed, as fully as possible, of all plans for him. After the patient goes to the hospital the doctor may be asked to plan further. It is preferable if the family take the patient to the hospital, and the doctor should insist that the family visit him while he is in the hospital. The doctor can help formulate even at this early date plans for bringing him back from the hospital and helping him enter the community, get his citizenship back, and become a member of his family again. All of these things may seem rather exhaustive for a family conference but this kind of planning can save the doctor many long hours of work in the months ahead, because this patient will undoubtedly come back from the hospital and if plans are made ahead of time, future management will be easier and the doctor's responsibility to the patient, to the family, and to the community can be restricted and less confused.

In addition to the family plan the doctor has a responsibility for alerting the family to the possibility of help within the community for their continued relationship with the patient and his return to the community. This can be facilitated by the use of the social welfare worker in the community, by the use of other social agencies in the larger community, such as Family Service, Child Service, or the court; and the use of the public health nurse, who in some counties in Georgia

already is concerned directly with the facilitating of the family's contact with the State Hospital and with the patient who is committed to it. She will interpret to the family State Hospital functions, will facilitate communication between the family and the hospital, and between the patient and the family while the patient is in the hospital. Furthermore she will accept a part of the responsibility for helping the family go ahead with commitment proceedings if such is the desirable and necessary plan.

Additional Responsibilities

Once the family and the doctor have arrived at a decision about the continuing care of the patient, certain things evolve on the doctor as additional responsibilities. If the patient is to be committed to a private hospital, the doctor is responsible for making certain that the family is not going to impoverish themselves in an effort to accomplish a long-term job with a limited budget. Private hospital care is expensive and it is the doctor's responsibility to keep the family from resolving their guilt about the patient by impoverishing themselves. Where the solution involves commitment to the State Hospital, the physician's responsibility is largely carried out with the completion of the plan, except that he should be available to the family for advice in case they get in trouble with the legal working-through of the plan. The referring physician may obtain from the Milledgeville State Hospital, upon written request, a summary of the work-up of his patient, including diagnosis, proposed treatment plan, and prognosis. He may also obtain, upon request, a resume of the patient's progress at any time.

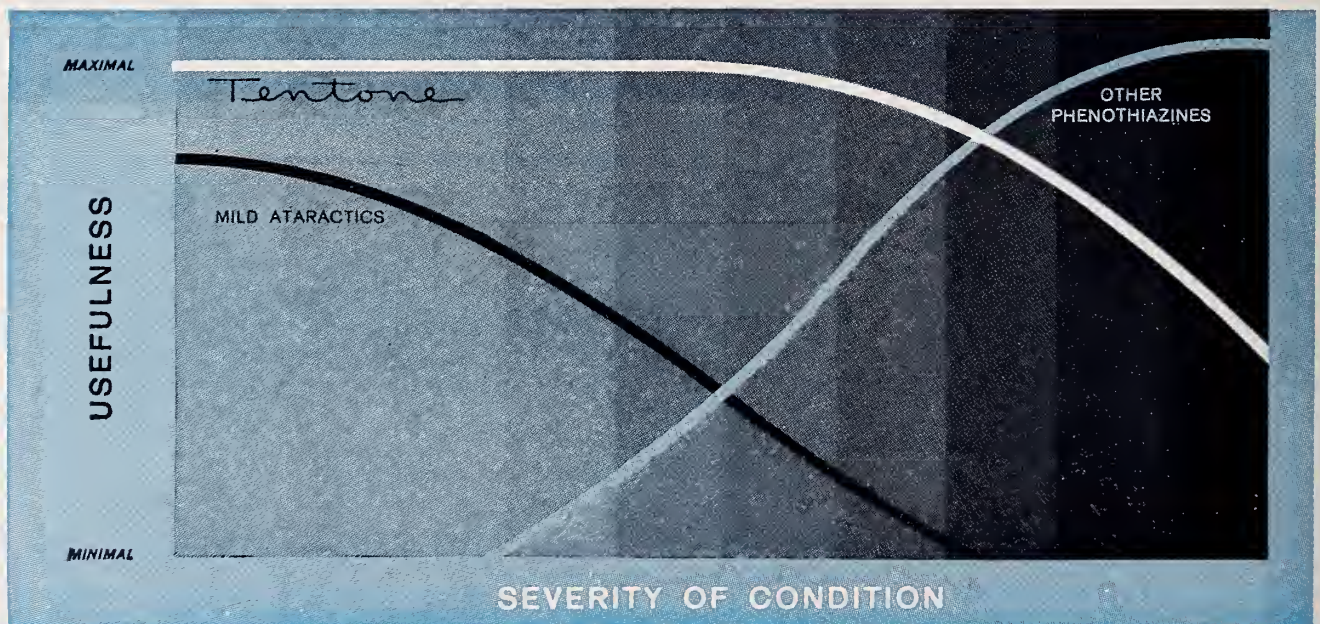
If the physician has a local hospital and it is possible to set up a private room for the care of such a patient, he may deem it wise to put the patient there for a short period of time for decision about the diagnostic picture and for help with working through the family's anxiety about hospitalization for long-term care. It may also be advisable to utilize such a general hospital for a brief period, say a week or ten days, while the family is considering and discussing between themselves the possibility of hospital-like care for the patient at home, or care in the general hospital. The family may arrive at such a decision, and someone in the family can be assigned to care for the patient, either in a general hospital, or in continuing care at home. It may be a sibling or one of the parents, but preferably someone who is not a part of the primary family, e.g., an aunt, a cousin, a nephew, may be available with whom the patient is in good rapport and who is willing and able to serve as a part-time nurse.

Summary

The hospitalization of the mentally ill is one of the most specific places in which the physician is not only a doctor of medicine but a family counselor, a member of the community in the most delicate sense. Furthermore, he is establishing his relationship to the public in a quite unique manner. It demands not only all of his professional skill but also, and maybe more important, his maturity and breadth as a person, his capacity for participation in other people's suffering, and his capacity to restrict his own professional responsibility within very firm boundaries.

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CAROTID ARTERY INSUFFICIENCY

Freeman H. Cary, M.D., *Atlanta*

IN RECENT YEARS, careful study and evaluation of stroke patients has made carotid artery insufficiency a common, easily recognized syndrome. An accurate history and complete physical examination with emphasis on certain diagnostic clues will lead the physician to this diagnosis with a high degree of accuracy.

As in atherosclerotic occlusions of other major vessels, occlusion of the internal carotid artery is more common in males over 40 years of age, although occlusions are not infrequently seen in younger age groups. Atherosclerosis in patients with normal blood pressure is commonly seen, but other diseases causing occlusive processes should be kept in mind.

Varying types of transitory neurological symptoms may be presented days, weeks, or even years before permanent brain damage occurs. Indeed, visual disturbances, local motor or sensory disturbances, hemiparesis, aphasia, or other transient symptoms may suggest brain tumor or other neurologic disorder. Likewise neurological signs may be fleeting. It should be mentioned that drugs or postural changes that produce decreases in the blood pressure may precipitate these symptoms and/or signs and care should be used in management of these patients if hypotensive agents are indicated. The carotid artery syndrome should be a prime diagnostic possibility in patients with transient neurologic symptoms or signs.

Carotid pulsations on the side opposite the symptoms and signs may be diminished or absent. The

internal carotid artery pulsations should be sought by gentle palpation of the lateral pharyngeal wall using a wet glove. Absence of the carotid or internal carotid pulsations with associated symptoms is almost unequivocal evidence of the syndrome. Occasionally a thrill is palpable over these vessels but more commonly a systolic bruit or continuous murmur is heard over the carotid artery or its bulb. It is best heard with the bell of the stethoscope making a light "air-seal" with the skin of the neck. Similarly systolic bruits or continuous murmurs may be heard over the eyeball on the side opposite the symptoms and/or signs and occasionally is heard over the ipsilateral eye apparently due to the rich anastomotic channels behind the eye. Again the most satisfactory results are obtained by use of the stethoscope bell. After first making a light "air-seal" over the closed eye, the patient is asked to "open" the eye to eliminate the muscle tremor produced on voluntary closure of the eye. Estimated retinal artery pressure can readily be determined using the ophthalmodynamometer. The gauge with a spring-load plunger is pressed against the lateral sclera by one observer while another physician observes the optic disc with the ophthalmoscope. As gentle pressure is applied, the retinal arteries are observed to pulsate indicating diastolic pressure; further pressure causes the pulsations to cease indicating systolic pressure. After some experience with this instrument, the team can determine retinal artery pressures rapidly, accurately, and without discomfort to the patient. The normal retinal artery pressure is about one-half systemic,

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

both systolic and diastolic. A variation of 25-30 per cent between the two sides is definite evidence of impaired carotid circulation on the side of the lower reading.

Angiography is useful selectively, especially in the 25 per cent of patients whose occlusive process is above the carotid artery bulb and in those who are under surgical consideration.

As yet, the treatment for this condition is not well formulated. Although long-term anticoagulation

seems to show promise, a controlled study involving a large series of patients has not been completed. Surgical repair, by-pass procedures, and endarterectomy are being reported with increasing frequency, but the efficacy of surgical treatment over medical management has yet to be established.

In summary, the syndrome of carotid artery insufficiency can be easily recognized on the basis of the history and careful physical examination. Auscultation over the neck and eyeballs and palpation of the carotid artery in the neck and the internal carotid artery in the pharynx are an integral part of the examination.

MEDICINE AND VOLUNTARY HEALTH INSURANCE

THE CHAIRMAN OF THE American Medical Association's Board of Trustees said today that medicine and voluntary health insurance are protecting the nation's senior citizens at a "rapid, accelerated pace." However, he warned that "we have only about one year left . . . a year in which we must work fast and vigorously" to provide coverage for additional millions of the aged or be confronted with tax-paid health care.

The Board chairman, Dr. Leonard W. Larson, said the nation must be concerned "not about the specific provisions of the Forand Bill—which can be amended all over the lot—but about the basic principles involved."

The bill, introduced in Congress by Rep. Aime Forand (D-R.I.), would provide hospital benefits and certain other services to persons receiving Social Security retirement and survivorship payments.

Dr. Larson, addressing the annual meeting of the Health Insurance Association of America at the Bellevue-Stratford Hotel, Philadelphia, said the principle of adding service benefits to the Social Security program, which so far has been limited to cash payments on the "floor-of-protection" concept, "would completely alter the nature of the program."

"It would open the door for evolution of a system of taxpaid health care for the entire population," he declared. "Every two years—in the even years of Federal elections—the familiar process of amendment and expansion would roll faster and farther. Such legislation first would undermine and eventually would destroy our system of voluntary health insurance and the private practice of medicine."

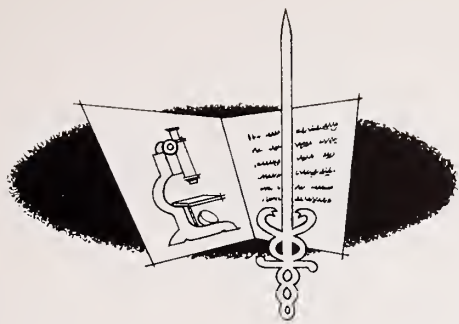
Dr. Larson took note of the rapid growth in health insurance coverage for senior citizens over the past few years and the "hopeful developments" of the last 12 months which have accelerated the pace even more. He cited the joint meeting of last October of representatives of the AMA, health insurance companies, Blue Cross and Blue Shield which resulted in various actions by each of these groups to extend health care cost protection to the over age-65 population.

But because health insurance coverage for older people is "the most urgent, critical field of activity" for Congress in the 1960 election year, Dr. Larson said, medicine and insurance must "work together more closely than ever before" to provide protection for the aged. He added:

"I honestly believe that if medicine and insurance will cooperate in a dramatic, convincing drive to increase the coverage of people over 65, we can take the steam out of those who advocate any Forand-type program. This will require open, clean, keen competition between voluntary insurers of all kinds—Blue Cross, Blue Shield, private insurance companies, and other sound agencies in the prepayment field—plus the wholehearted support of the medical profession."

Dr. Larson declared that the future of private medicine in the United States "no longer depends primarily upon scientific progress and the professional competence of physicians," adding:

"In these times of swirling social, economic, and political pressures, private medicine may stand or fall in relation to the success or failure of voluntary health insurance . . ."



cancer page

SKIN CANCER

Lester Harbin, M.D., *Rome*

CARCINOMAS of the epidermis or so-called "skin cancers" are encountered almost daily by the general physician with an active practice. Too often they are over-looked or are ignored until they have progressed to the point of no return. Because of their slow rate of growth, procrastination on the part of the patient and physician is all too frequent. As with other cancers, they can be cured if they are detected in such a stage that all of the malignant cells can be destroyed or surgically eradicated.

This type of carcinoma is more prevalent in our southern section of the country. Those blond individuals with thin skins who indulge in occupations and recreations which involve prolonged and direct exposure to the sun are more susceptible to this form of cancer. Adequate protection from the sun in the form of proper clothes and hats as well as actinic filters in the forms of lotions and ointments are worthwhile prophylactic measures if persistently used. It is unfortunate that in those individuals who have a tendency to develop such tumors, multiple lesions are frequent. Although separate and distinct neoplasms two or more lesions in the same individual are not infrequent. Constant observation on the part of the physician and patient is a must for all questionable skin changes. Patients should be advised to seek medical advice if they have skin lesions which do not heal, which bleed, or which are increasing in size.

Although the clinical impression of those of great experience carries a higher degree of diagnostic ac-

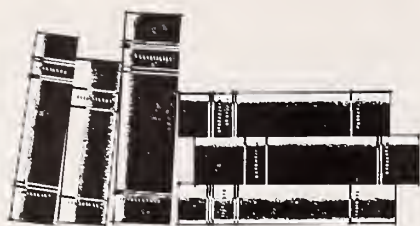
curacy than in most fields, biopsies and the opinion of the pathologist is always the procedure of choice. This confirms the clinical impression and gives an unquestionable diagnosis. Basal cell epitheliomas do not usually metastasize whereas squamous cell carcinomas do metastasize via the lymphatics. This latter type of carcinoma should be attacked more vigorously and at times the adjacent lymph nodes must be removed in order to effect a cure. These lesions are treated by (1) surgery, (2) radiation, or (3) desiccation. The microscopic diagnosis helps determine which modality of treatment is preferable. The doctor who treats these lesions the first time has the best chance to cure the patient. All forms of treatment should be designed to remove or eradicate all of the cancer cells. If radiation is used in inadequate doses, the local recurrence, which is inevitable, will not only be radioresistant but will also be more difficult to excise surgically, thus decreasing the chance for a successful result.

No other carcinoma lends itself so well to early diagnosis. The patient can usually see it; the doctor can always see it.

They can be cured if:

- (1) The patient is alerted through proper cancer education
- (2) Physicians biopsy all suspicious skin lesions
- (3) The physician who treats the patient the first time gives treatment adequate to eradicate all of the malignant cells.

Approved by Professional Education Committee, Georgia Division, ACS.



physician's bookshelf

BOOKS RECEIVED

Ronson, Stephen Wolter, M.D., Ph.D., **THE ANATOMY OF THE NERVOUS SYSTEM**, W. B. Saunders Company, Philadelphia, Pa., 1959, 622 pp.

Turell, Robert, M.D., **DISEASES OF THE COLON AND ANORECTUM**, W. B. Saunders Company, Philadelphia, Pa., 1959, 1238 pp., 2 vols.

NEW AND NONOFFICIAL DRUGS, an annual publication issued under the direction and supervision of the AMA, J. B. Lippincott Company, Philadelphia, Pa., 1959, \$3.35, 687 pp.

Schiffes, Justus J., Ph.D., **THE FAMILY MEDICAL ENCYCLOPEDIA**, Little, Brown and Company, Boston, Mass., 1959, \$4.95, 617 pp.

Riese, Wolter, M.D., **A HISTORY OF NEUROLOGY**, MD Publications, Inc., New York, N. Y., 1959, \$4.00, 223 pp.

Weil, Poul G., B.A., M.D.C.M., M.Sc., Ph.D., **THE PLASMA PROTEINS**, J. B. Lippincott Company, Philadelphia, Pa., 1959, \$3.50, 133 pp.

Goodrich, Frederick W., Jr., M.D., **MATERNITY**, Prentice-Hall, Inc., Englewood Cliffs, N. J., \$1.75, 130 pp.

Conn, Howard F., M.D., **CURRENT THERAPY—1959**, W. B. Saunders Company, Philadelphia, Pa., 1959, 781 pp.

Blanton, Smiley, M.D., **NOW OR NEVER**, Prentice-Hall, Inc., Englewood Cliffs, N. J., 1959, \$4.95, 273 pp.

Moseley, H. Fred, M.A., M.D., M.Ch. (Oxon), F.A.C.S., F.R.C.S. (Eng.), F.R.C.S. (C), **TEXTBOOK OF SURGERY**, The C. V. Mosby Company, 1959, \$17.00, 1336 pp.

Lamm, Stanley S., M.D., **PEDIATRIC NEUROLOGY**, Landsberger Medical Books, Inc., New York, N. Y., 1959, \$12.90, 495 pp.

Duncan, Gorfield G., M.D., **DISEASES OF METABOLISM**, W. B. Saunders Company, Philadelphia, Pa., 1959, 1104 pp.

United States Department of Defense, **SURGERY IN WORLD WAR II, NEUROSURGERY, VOL. I**, Published by the Surgeon General, Department of the Army, U. S. Government Printing Office, Washington, D. C., 1959, \$5.00, 466 pp.

Moss, William T., M.D., **THERAPEUTIC RADIOLOGY**, The C. V. Mosby Company, St. Louis, Mo., 1959, \$12.50, 403 pp.

Moy, Jacques, M., M.D., **THE ECOLOGY OF HUMAN DISEASE**, MD Publications, Inc., New York, N. Y., 1959, \$7.50, 327 pp.

Arrington, George E., Jr., M.D., **A HISTORY OF OPHTHALMOLOGY**,

MD Publications, Inc., New York, N. Y., 1959, \$4.00, 174 pp.

Wochtel, Curt S., M.D., **YOUR MIND CAN MAKE YOU SICK OR WELL**, Prentice-Hall, Inc., Englewood Cliffs, N. J., 1959, \$4.95, 244 pp.

Clyne, Douglas G. Wilson, B.M., B.Ch., M.A. (Oxon), L.R.C.P., F.R.C.S. (Edin.), M.R.C.O.G., Barrister-at-law, **A HANDBOOK OF OBSTETRICS AND GYNECOLOGY FOR NURSES**, The Williams & Wilkins Company, Baltimore, Md., 1958, \$4.00, 204 pp.

Wolstenholme, G. E. W., O.B.E., M.A., M.B., B.Ch. and O'Connor, B.A., **CIBA FOUNDATION SYMPOSIUM ON THE BIOSYNTHESIS OF TERPENES AND STEROLS**, Little, Brown and Company, Boston, 1959, \$8.75, 311 pp.

Boies, Lawrence R., M.D., **FUNDAMENTALS OF OTOLARYNGOLOGY**, W. B. Saunders Company, Philadelphia, Pa., 1959, 510 pp.

Roques, Frederick W., C.B.E., M.D., M.Chir., F.R.C.S., F.R.C.O.G., **DISEASES OF WOMEN**, The Williams & Wilkins Company, Baltimore, Md., 1959, \$8.00, 556 pp.

Kelly, G. Lombard, A.B., B.S.Med., M.D., **A DOCTOR DISCUSSES MENOPAUSE**, The Budlong Press, Chicago, Ill., 1959, \$1.50, 90 pp.

Canfield, Norton, M.D., **HEARING**, Doubleday & Company, Inc., Garden City, N. Y., 1959, \$3.50, 214 pp.

Pugh, Herbert Lomont, (M. C. Ret.), **NAVY SURGEON**, J. B. Lippincott Company, Philadelphia, 1959, \$5.00, 459 pp.

Marti-Ibonex, Felix, M.D., **HISTORY OF AMERICAN MEDICINE**, MD Publications, New York, N. Y., 1959, \$4.00, 181 pp.

De Takots, Geza, **VASCULAR SURGERY**, W. B. Saunders Company, Philadelphia, Pa., 1959, 726 pp.

THE READER'S APPETITE will be so whetted by Dr. de Takats' new book on vascular surgery that it will undoubtedly serve as his standard reference for diseases of the peripheral vessels. There is no cardiac or cardiothoracic subject discussed since this book registers only the personal experiences of the author and his group. The book begins with a discussion of the fundamental principles affecting vascular surgery and the methods used in diagnosis. The various vascular syndromes requiring surgery care are next described in detail fol-

lowed by a section on surgical techniques. The illustrations are outstanding and make the reading easy and clear. This monograph is recommended for anyone (medical student or specialist) who wishes to gain a fundamental understanding of the peripheral vascular abnormalities that can be altered by surgery.

Milton F. Bryant, M.D.

Gofman, John W., WHAT WE KNOW ABOUT HEART ATTACKS, Putnam, 1959, 180 pp.

THIS BOOK, INTENDED for the layman, is a discussion of possible etiological factors in coronary artery disease. It is not concerned with symptomatology or treatment. The author devotes a chapter each to: fat embolism, age, obesity, hypertension, heredity, sex incidence, cigarette smoking, occupation, exertion and mental stress, and diabetes. As those who are acquainted with the author's other works would expect, there is particular emphasis on the Sf classification of lipoproteins and the atherogenic index. The final chapter advises routine lipoprotein analysis and the institution of dietary restrictions if the atherogenic index is elevated.

Generally the material is presented well and in considerable detail, probably more detail than the average layman would find necessary. The ideas presented are generally in line with current medical thought except for the unwarranted conclusion that lipoprotein analysis is the most satisfactory method of studying the blood fats.

This book could be of interest to medical or nursing students and to unusually interested laymen. Your patient who reads it will have good insight into the causes of heart attacks and profound respect for lipoprotein analysis.

J. Grant Wilmer, M.D.

Marti-Ibanez, Felix, M.D., MEN, MOLDS, AND HISTORY, MD Publications, Inc., New York, 1958, \$3.00, 116 pp.

THE AUTHOR HAS GATHERED together in this small vol-

ume a series of papers delivered by him over a period of four years prior to 1957. In these papers, he has traced the history of antibiotics and discusses not only what is happening in the present, but what may be expected to happen in the next half century. He binds the story of antibiotics together with a very pleasant and optimistic philosophy and includes a eulogy of Sir Alexander Fleming.

In view of its broad scope, this book is not for the student nor the research worker. It is not a textbook. It is an interesting book for a physician who might be interested in the philosophy of this phase of medicine rather than in the science of antibiotics. It is well written and interesting.

Chris J. McLoughlin, M.D.

Prior, John A and Silberstein, Jack, PHYSICAL DIAGNOSIS, C. V. Mosby, St. Louis, 1959, \$7.50, 388 pp., 193 illustrations.

THIS IS AN UNPRETENTIOUS student's companion adequately fulfilling the author's purposes. Basic techniques of examining the various systems are emphasized. Discussion of pathology is limited by design. The format is excellent. The book is not aimed for the physician's reference shelf.

Some might disagree on occasion with the author's didactic techniques. More examples of the abnormal might, by contrast, help define the normal. Although eponyms are avowed as worthless, they are inconsistently and perhaps injudiciously eliminated. For example "Kronig's isthmus" is not indexed or mentioned and as a consequence, this important fact, although described, receives no emphasis.

Since the subject is actually enormous and space always limited, reviewers will eternally carp at such books—until they write one themselves.

A. Calhoun Witham, M.D.

ADMINISTRATION OF TRANQUILIZERS TO CHILDREN

GREAT CAUTION WAS urged in administration of tranquilizing drugs to children, pending considerably more research on their effects, by several speakers at a symposium held recently in Washington, D. C., under sponsorship of the National Institute of Mental Health.

The question as to whether or not the tranquilizing drugs may retard a child's development was raised repeatedly. Dr. Leon Eisenberg, assistant professor of psychiatry and pediatrics at Johns Hopkins Hospital, Baltimore, suggested the possibility that the tranquilized child patient may "pay for his symptomatic relief at the cost of lowered mental acuity and dexterity."

Despite questions and warnings, a widening scope in use of tranquilizers for children was noted by Dr.

Reginald S. Lourie, director of psychiatric services of Children's Hospital, Washington, D. C. First experiments, he said, were confined to the "mentally defective, the psychotic, the extremely over-active or acting-out child." Since then, however, they have been used in a wide range of problems, although "there still isn't enough basic research to give us agreement on appropriate uses and dosages."

A survey of use of the drugs in the practices of 250 members of the medical staff of one large children's hospital showed about 35 per cent were prescribing tranquilizers, Dr. Lourie reported. "The vast majority of these were pediatricians. Of the 65 per cent who didn't, 17 per cent were pediatricians, the rest surgeons," he stated.



abstracts by georgia authors

Bryans, Charles I., Jr. and Mulherin, Charles McL., St. Joseph's Hospital, Augusta, Georgia, "The Use of Chlorpromazine in Obstetrical Analgesia," *Am. J. Obst. & Gynec.* 77:406-411 (Feb) 59.

In Augusta, Georgia, for the past 10 years or more, practically all the obstetricians have used intravenous barbiturates for obstetrical analgesia as described by Volpito in 1946. This method has been a fairly satisfactory one, but we were dissatisfied with the rather high incidence of maniacal excitement and the comparatively large number of depressed babies. Therefore, when the early reports on the use of chlorpromazine (Thorazine®) came out in this country, we decided that this drug was worthy of a trial.

When the patient was in well-established labor and began to complain of discomfort she was given 25 mg. of chlorpromazine, 50 mg. of meperidine, and 0.6 mg. of scopolamine all mixed in the same syringe and injected in the gluteal muscle. The medication was repeated in doses of half this amount as needed throughout labor. The second dose was usually given in about one hour and subsequent doses at intervals of two to three hours. From November 23, 1954, through December 31, 1956, 628 patients received chlorpromazine in total dosage ranging from 25 to 150 mg. The mean total dose of the three drugs was chlorpromazine, 50 mg., meperidine, 100 mg., and scopolamine, 1.2 mg. Five hundred eighty-one patients delivered by the same two obstetricians in the same hospital in the year preceding this study, or from November 23, 1953, through November 22, 1954 were studied for comparison.

The following conclusions were reached: chlorpromazine had no effect on the duration of labor; it did not increase the total number of operative deliveries but may have increased the incidence of midforceps; the incidence of respiratory depression in the infants of the chlorpromazine patients was less than one half that found among the babies delivered in the year prior to the use of this drug; there was only one episode of hypotension in the whole series. There was no incidence of jaundice. Also, there were no significant hypotension and no jaundice in approximately 1,800 other women, patients of other doctors, who were delivered in the same hospital during the course of this study; the patients were quiet and cooperative,

and the incidence of amnesia was nearly 100 per cent.

Sheldon, Walter, Emory University School of Medicine, Atlanta 22, Georgia, "Subclinical Pneumocystis Pneumonitis," *J. Dis. Children* 97:287-297 (March) 59.

Pneumocystis carinii infection of the lung was encountered as an incidental autopsy finding in four native American children. Two were white females: one, three months old, and the other, 10 years old. The other two were male negro siblings, aged three and one half and four months old. The morphologic lesions consisted of a slight focal interstitial pneumonitis which had produced no detectable clinical manifestations.

These findings indicate that in this country pulmonary pneumocystis infection may not be infrequent, particularly in subclinical form when it is associated only with mild and focal lung changes, and affects older children as well as infants. An appraisal of the available data suggests that in the normal host pneumocystis carinii is of low virulence and that host resistance must be severely impaired before the parasite can proliferate sufficiently to produce clinically manifest disease.

Rivarola, Carlos H., Crawford W. Long Hospital, Atlanta, Georgia, "Carcinomas of the Appendix," *Am. Surgeon* 25:211-213 (April) 59.

Primary malignant tumors of the appendix are encountered infrequently with the exception of carcinoid. The incidence is difficult to determine because of the inaccurate early literature which failed to distinguish between adenocarcinoma and tumors that we designate as carcinoid.

In reviewing 441 cases of carcinoma in the gastrointestinal tract at Crawford W. Long Memorial Hospital, Atlanta, Georgia, 171 originated in the colon, 169 in the rectum, 75 in the stomach, nine in the small bowel, eight in the esophagus, and seven in the appendix. This represents an incidence of 1.5 per cent of the total gastrointestinal carcinomas treated in this hospital.

The correct preoperative diagnosis was never made or even suspected in any patient of this group.

These seven patients may be grouped into five diagnostic classes:

1. The majority of these lesions are discovered incidentally at the time of surgery for other pathology.

2. Malignant lesions of the appendix are not infrequently discovered at

operations for acute appendicitis.

3. Carcinoma of the appendix is discovered on physical examination as a mass in the RLQ.

4. Metastatic lesion on neck for an adenocarcinoma of the appendix.

5. Malignant argentaffinomas are encountered in an apparently normal gross appendix.

Bartholomew, R. A.; Colvin, E. D.; Grimes, Wm. H., Jr.; Fish, J. S.; Lester, Wm. M.; and Galloway, Wm. H., 272 Boulevard, Atlanta 12, Georgia, "Utopian Obstetrics—In Retrospect," *Am. J. Obst. & Gyn.* 77:450-458 (Feb) 59.

An article entitled "Utopian Obstetrics" was published by the senior author in 1942. Written as a contemplated project, it is now re-written in retrospect after being practiced for the past ten years.

The principal motivations toward group practice are (1) to permit a more normal and better way of life, (2) to reduce overhead expenses, (3) to facilitate consultations and assistance, (4) to provide substitution in cases of illness, (5) to afford patients more security by a system of constant availability, and (6) to afford group members more security in the declining years of practice.

It can be tailored to the requirements of any specialty although better adapted to some fields of practice than others. The manner of rotation of service, insurance protection, division of income and expenses, method of building up a group, financial arrangements with patients, and the educational and research advantages are discussed.

The continued growth of this manner of practice is an indication of its appeal to patients. It could well be a bulwark against the creeping inroads of socialized medicine.

Keller, A. Paul, Jr., 1010 Prince Avenue, Athens, Georgia, "Some Considerations Concerning Chicken Bones in the Esophagus," *South. M. J.* 52:414-418 (April) 59.

The rise to prominence of the chicken industry in the South has given us occasion to consider more closely some of the aspects of chicken bones as foreign bodies in the human esophagus. Type of bone most often encountered, difficulty in diagnosis and type of patient most often seen are discussed as well as some points concerning endoscopic removal. Several cases are presented to illustrate the more pertinent features of diagnosis and endoscopic removal.

M. S. H REPORT—EXAMPLE OF FINE COMMITTEE WORK

AS THIS IS MY first official letter as the new President of the Medical Association of Georgia, it is with the greatest pleasure that I send to each of you my warmest greetings and most profound thanks for the trust you have shown and the support you have given to me! I face the somewhat stern duties of the coming year with the utmost confidence, knowing that I have a great store of intelligence, energy, talent, and good-will among the membership to help and to advise me in the many problems and situations that will inevitably confront us in the next 12 months.

The affairs of the Association have become so vast and complex, and display so many facets and ramifications, that one man cannot possibly be expected to understand completely, nor to perform personally, these many affairs. It is only through the conscientious and painstaking work of committees that progress will be achieved.

An exemplary specimen of fine committee work has recently been accomplished by the Special Committee appointed at the request of Governor Vandiver to investigate the Milledgeville State Hospital. This Committee, although appointed on very short notice, immediately held the necessary hearings, came up with the basic problems involved, and offered concise and intelligent recommendations for the corrections of the existing deficiencies. The Governor has fortunately seen fit to follow and to put into effect most of the major recommendations with commendable speed and dispatch. The report of this committee has been acclaimed widely in the editorial columns of the press through the state, and has been of inestimable value in demonstrating to the public the selfless and dedicated attitude of the medical profession. Incidentally, the expenses, including legal and clerical expenses, were borne by the Medical Association of Georgia—a considerable financial item. The members of this Special Committee were: W. Bruce Schaefer, Toccoa, Chairman; R. Hugh Wood, Atlanta; Corbett Thigpen, Augusta; Rives Chalmers, Atlanta; and John Bell, Dublin. All credit and appreciation is due these men for a superlative job well done!



Luther H. Wolff

President, Medical Association of Georgia



the association

ANNOUNCEMENTS

The Arthritis and Rheumatism Foundation offers pre-doctoral, post-doctoral, and senior investigatorship awards in the fundamental sciences related to arthritis for work beginning July 1, 1960. Deadline for applications is October 31, 1959.

These awards are intended as fellowships to advance the training of young men and women of promise for an investigative or teaching career. They are not in the nature of a grant-in-aid in support of a research project.

A sum of \$500 will be paid to cover the laboratory expenses of each postdoctoral fellow and senior investigator. An equal sum will be paid to either cover the tuition expenses or laboratory expenses of each pre-doctoral fellow.

For further information and application forms, address the Medical Director, Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, N. Y.

The University of Southern California School of Medicine will offer another Postgraduate Refresher Course in Hawaii and on board the S.S. Lurline from July 29 through August 15, 1959.

In addition to the lectures, there will be workshops in ECG and X-ray interpretation as well as problems of water and electrolyte balance and the differential diagnosis of jaundice. During most hours, several programs run simultaneously so that the participating physician may choose the topics most suited to his needs.

Further information about the course may be obtained by writing to the Director of the Postgraduate Division, USC School of Medicine, 2025 Zonal Avenue, Los Angeles 33, California.

The Second Ruidoso Summer Clinics has been set for July 20-23, 1959 at Ruidoso, New Mexico. An excellent program has been arranged. Pre-registration fee is \$20.00 and registration at Ruidoso will be \$25.00.

Accommodations may be secured by writing to Dr. A. B. Alexander, Box 694, Ruidoso, New Mexico.

Rooms are secured at the several motels and should be reserved as soon as possible.

The First International Medical Conference on Mental Retardation will be held July 27-31, 1959 in The Eastland Hotel at Portland, Maine.

Simultaneous translation from and into other languages at general sessions, is planned.

Please address all communications to: Conference Secretary, International Medical Conference on Mental Retardation, c/o Division of Maternal and Child Health, State House, Augusta, Maine.

The next Pan American Medical Association Congress will meet in Mexico City, May 2-11, 1960.

The scientific program, through its 48 different medical sections, will include all branches of medicine and surgery, dentistry, hospital administration, and medical education.

New sections added since the last Pan American Medical Association Congress include space medicine, hematology, cancer cytology, and a large section on general practice. There will be many special panels, including pharmacology and new drugs, mental diseases, nutrition, relationship of dentistry to medicine, cancer research, sudden deaths, medical press relations, and others.

For information write Dr. Joseph J. Eller, Director General, 745 Fifth Avenue, New York, N. Y.

DEATHS

CHARLES CLYDE ADAMS, Buckhead physician and active civic worker, died April 17 at his home at the age of 58.

A graduate of Georgia Tech and Emory Medical School, Dr. Adams had been practicing in north Atlanta since 1944. He was a member of the Medical Association of Georgia, the Fulton County Medical Society, the American Medical Association, and Phi Rho Sigma medical fraternity.

Born in Atlanta, he had lived here all his life. He served with the U. S. Army in World War I, and was

a charter member of the Waldo M. Slaton Post No. 140, American Legion. He was a past president of the Buckhead Century Club and a past master of Sardis Lodge No. 107, F. & A. M. He was a member of the Peachtree Road Methodist Church.

Surviving are his wife; three daughters, Mrs. Daniel Frank Wilt, Miss Alice Amelia Adams, and Miss Alecia Arlene Adams, all of Atlanta; one aunt and three grandchildren.

MARVIN M. HEAD, former president of the Medical Association of Georgia and a practicing physician in Pike County and Zebulon for 57 years, died March 31 at his home after an illness of several months.

He was president of the Medical Association of Georgia in 1932 and was a member of the American Medical Association. He served as a captain in the U. S. Medical Corps during World War I.

A native of Meriwether County, he was graduated from Gordon Military Institute in Barnesville in 1898 and from the Atlanta College of Physicians and Surgeons in 1902.

Survivors include his wife; a son, Marvin N. Head, Zebulon; a sister, Miss Lutie Head, Zebulon; two brothers, Dr. Douglas L. Head, Zebulon and H. W. Head, Anniston, Ala.; one granddaughter; and two great granddaughters.

SOCIETIES

The GEORGIA MEDICAL SOCIETY held its regular meeting recently, Dr. Kou Freedman moderating the program, which included a symposium on civil defense.

Dr. Herbert A. Claiborne, assistant professor of obstetrics and gynecology at the University of Virginia Medical School, addressed the April meeting of the MUSCOGEE COUNTY MEDICAL SOCIETY.

The Augusta Graduate Assembly, sponsored by THE RICHMOND COUNTY MEDICAL SOCIETY, was held in Augusta recently.

Dr. Folke Becker presented a paper, "Medical Hypnosis in Physical Medicine and Rehabilitation" before an assembly of the SOUTHEAST GEORGIA MEDICAL SOCIETY in Vidalia.

Seventy-five doctors and wives from the FIRST DISTRICT MEDICAL SOCIETY met recently in Statesboro for their annual meeting. The following officers were elected: president, Randall G. Brown, Swainsboro; president-elect, William H. Fulmer, Savannah; vice-president, Albert M. Deal, Statesboro; secretary, David Robinson, Savannah; and treasurer, John Mooney, Statesboro.

The SECOND DISTRICT MEDICAL SOCIETY held a regular business meeting in Tifton recently. Dr. Luther Wolff of Columbus, president of the Medical Association of Georgia was a guest at this meeting.

The THIRD DISTRICT MEDICAL SOCIETY met recently at the Americus Country Club with the SUMTER COUNTY MEDICAL SOCIETY as host.

At a recent meeting of the SEVENTH DISTRICT MEDICAL SOCIETY in Rome, Ralph Fowler was elected to represent the district on the Council of the

Medical Association of Georgia. Elected to serve as vice-councilor was Ralph Johnson of Rome. Remer Clark of Marietta was elected for a two year term as secretary of the district association and Oliver Jenkins of Lindale was elevated to the office of president-elect.

The NINTH DISTRICT MEDICAL SOCIETY held its semi-annual meeting in Gainesville at the Gainesville Elks Lodge.

PERSONALS

First District

DAN WILLOUGHBY of Savannah discussed the medical aspects of tuberculosis at the district meeting of registered nurses at St. Joseph's Hospital School of Nursing in Savannah.

CURTIS HAMES of Claxton spoke to the student body of the Medical College of Georgia in Augusta at the Talmadge Memorial Hospital auditorium. His subject was "A Lipid Mobilizing Factor and its Possible Role in Atherosclerosis."

JULIAN QUATTLEBAUM, JR. and TOM FREEMAN, of Savannah; CURTIS HAMES of Claxton, and CHARLES T. BROWN of Guyton appeared on the scientific panel held at the First District Medical Society's annual meeting in Statesboro.

Second District

The new president of the Southeastern Section of the American Urological Association is RUDOLPH BELL, of Thomasville.

HENRY K. JARRETT of Tifton spoke on "Primary Carcinoma of the Ureter and Renal Pelvis" and ROBERT E. FOKES of Moultrie spoke on "Retrolental Fibroplasia" at a recent meeting of The Second District Medical Society held in Tifton.

Third District

ROBERT VAUGHAN of Columbus told of experiences with vascular surgery at a recent meeting of The Third District Medical Society held in Americus.

Fourth District

No news submitted.

Fifth District

DAN BURGE of Atlanta was the guest speaker of the Cartersville Lions Club.

JOHN THOMPSON, Grady Hospital, Atlanta, spoke to The Third District Medical Society on "Management of Adnexal Mass," at their meeting held in Americus.

Recently TRUETT BENNETT of Atlanta lectured on "Surgery of the Larynx" to the surgical staff of the VA Hospital at Augusta.

VERNON POWELL, MAURICE CLARKE, DAN HANKEY, JOHN McCOY, and ARTHUR PRUCE all of Atlanta took part in a panel discussion sponsored by the Georgia Chapter of Arthritis and Rheumatism.

One of the speakers at the Augusta Graduate As-

sembly was JOHN S. ATWATER, associate in medicine at Emory University, Atlanta.

CARL WHITAKER, Atlanta psychiatrist, spoke to the Josephine Wells P.T.A. recently.

The keynote address at the kick-off dinner for the annual cancer fund drive for Gwinnett County was given by ROBERT L. BROWN of Atlanta.

JACK NORRIS introduced the speaker, Dr. Milford O. Rouse, of Dallas, Texas, president of the Southern Medical Association, at the kick-off dinner honoring the Atlanta Committee on Arrangements for the 53rd Annual Meeting of the Southern Medical Association scheduled for November 16-19 here in Atlanta.

A. H. LETTON gave a series of lectures at the VA Hospital in Augusta and the Medical College of Georgia recently.

VERNELLE FOX and DAN KAHLE of Atlanta appeared on Press Gallery, WSB-TV.

JOHN STEGEMAN, Atlanta, spoke at the Tuckston Methodist Church, continuing their series on "Abundant Living."

Sixth District

No news submitted.

Seventh District

The Cartersville Rotary Club recently elected HARVEY HOWELL as their new president.

Eighth District

SAGE HARPER of Douglas was recently honored by his many friends from the Ambrose and Wray communities on Doctors' Day. They presented him an engraved bronze plaque expressing their appreciation.

DANIEL H. G. GLOVER, district director of Public Health in Jesup, was the guest speaker at the regular meeting of the Blackshear Woman's Club.

WILLIAM DANIEL MIXSON, Waycross, was recently honored on his 89th birthday. An Open House was held at his home in order for many friends to call.

Ninth District

No news submitted.

Tenth District

CAROL PRYOR, president of the Augusta Branch of the American Association of University Women and second vice-president of the Georgia Division, was in charge of the program for the Annual Conference of the Georgia Division, AAUW held in Augusta recently.

JULIUS T. JOHNSON, clinical instructor in psychiatry at the Medical College of Georgia, has announced the opening of private practice in psychiatry and neurology.

The key speaker at The Second District Medical Society's recent meeting was THOMAS FINDLEY, chairman of the Department of Medicine at the Medical College of Georgia.

VIRGIL P. SYDENSTRICKER, professor emeritus of medicine at the Medical College of Georgia, discussed "The Pellagra Story" before the student body of the Emory Medical School.

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Clockwise, starting at upper left, Curtis P. Artz, M.D., Jackson, Miss.; Louis M. Orr, M.D., Orlando, Fla.; Paul Dudley White, M.D., Boston, Mass.; Louis K. Diamond, M.D., Boston, Mass.; Lee Howard, Sr., M.D., Savannah, Ga.; Luther H. Wolff, M.D., Columbus, Ga.; and Milford B. Hatcher, M.D., Macon, Ga.—Photos by Ted F. Leigh, M.D., Atlanta.

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M. W. Hurt, Sandersville, Secretary

75—WAYNE

Albert L. Howard, Jesup, President
Robert A. Pumpelly, Jesup, Secretary

76—WHITFIELD

L. C. Yeargin, Dalton, President
John Looper, Jr., Dalton, Secretary
Mrs. J. E. Lord, Dalton, Executive Secretary

78—WILKES

Harry Cheves, Jr., Union Point, President
M. C. Adair, Washington, Secretary

79—WORTH

J. L. Tracy, Sylvester, President
H. G. Davis, Jr., Sylvester, Secretary

OFFICIAL PROCEEDINGS

***105th Annual Session**

of the

MEDICAL ASSOCIATION OF GEORGIA

Bon Air Hotel, Augusta, May 17-20, 1959

First Session, House of Delegates (PAGE 308)

Second Session, House of Delegates (PAGE 312)

First General Business Session (PAGE 363)

Second General Business Session (PAGE 364)

* In 1956 it was brought to the attention of the House of Delegates that the numbering of Annual Sessions was inconsistent with the actual number of sessions. To rectify this mistake, this session, instead of being the 109th, is the *105th.

*105th MAG ANNUAL SESSION PROCEEDINGS INDEX

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FIRST SESSION, HOUSE OF DELEGATES

Sunday, May 17, 1959

THE FIRST SESSION of the House of Delegates of the Medical Association of Georgia was called to order by Speaker Thomas W. Goodwin, Augusta at 5:05 P.M., Sunday, May 17 in the Crystal Room, Bon Air Hotel, Augusta, Georgia in conjunction with the *105th Annual Session of the Association.

Speaker Goodwin delivered the invocation.

Speaker Goodwin then called for the preliminary report of the delegates' attendance by Eustace A. Allen, Atlanta, Chairman of the House Credentials Committee. As the preliminary report was late in forthcoming, Speaker Goodwin ruled that there obviously was over a quorum of 40 delegates present at this time. Dr. Allen later made the following complete report on attendance.

Attendance

In a compilation of attendance taken from the official roll, 56 county medical societies were represented by their duly elected delegates or alternates. Seventeen county medical societies were not represented at this First Session. Of a total of 139 authorized delegates from their respective medical societies, the official roll showed 109 delegates present at this First Session.

ALTAMAHA: J. B. Brown; BALDWIN: Melvin M. Smith, Zeb Burrell, Jr.; BEN HILL-IRWIN: Ralph D. Roberts, Fitzgerald; BIBB: Milford B. Hatcher, E. C. McMillan, Rudolph Jones, Macon, Tom Williams, Braswell Collins, Jule C. Neal, Jr.; BURKE: Lamar Murray; CARROLL-DOUGLAS-HARALSON: F. M. Parks, R. L. Denny; CHATTAHOOCHEE: Marcus Mashburn; CHATTOOGA: William P. Martin; CHEROKEE-PICKENS: C. J. Roper; CLAYTON-FAYETTE: F. A. Sams, Jr.; COBB: E. P. Inglis, Jr., Bruce D. Burleigh, W. C. Mitchell; COFFEE: Calvin S. Meeks, Jr.; COLQUITT: John P. Tucker; COWETA: Ben H. Jenkins; DeKALB: Floyd Sanders, L. H. Vinton, Jr.; DOUGHERTY: Charles G. Lamb, W. P. Rhyne; EMANUEL: R. J. Moye; FLINT: Charles E. McArthur; FLOYD: Ralph Davis; FRANKLIN-HART-ELBERT: Louis Cacchiolo; FULTON: Harold P. McDonald, Thomas J. Anderson, Jr., J. Frank Walker, William Coles, Mason Lowance, Lamar B. Peacock, Exum Walker, James H. Byram, Linton H. Bishop, Jr., Fleming L. Jolley, Edwin C. Evans, B. L. Shackelford, H. Walker Jernigan, John W. Turner, Marvin A. Mitchell, John S. Atwater, Don F. Cathcart, Major F. Fowler, Mark S. Dougherty, Hugh Hailey, Lester Rumble, J. D. Martin, Jr.; GEORGIA MEDICAL SOCIETY: David Robinson, John L. Elliott,

W. H. Fulmer, Ruskin King; GLYNN: C. A. Wilson, Joseph B. Mercer; GORDON: Lewis R. Lang; HALL: Rafe Banks, Jr., Henry S. Jennings; JACKSON-BARROW: P. T. Scoggins; JASPER: M. L. Greene; JEFFERSON: C. Roy Williams; JENKINS: A. P. Mulkey; LAURENS: William A. Dodd; CRAWFORD W. LONG: R. H. Randolph, James A. Green; McDUFFIE: A. G. Leroy; MERIWETHER-HARRIS: William Chambless; MUSCOGEE: Willis P. Jordan, Luther Roberts, S. A. Roddenbery, Charles R. Smith; NEWTON: J. C. Brown; OCMULGEE: William G. Coleman; OCONEE: J. H. Nicholson; POLK: Don Schmidt; RABUN: George H. Boyd, Jr.; RICHMOND: A. J. Waters, J. L. Chandler, W. A. Fuller, F. N. Harrison, C. M. Templeton, R. G. McGahee, A. M. Battey, C. B. Shiver; SCREVEN: Katrine R. Hawkins; SOUTH GEORGIA: F. G. Eldridge, A. G. Little, Jr.; SOUTHWEST GEORGIA: James Martin; SPALDING: Virgil B. Williams, Jackson W. Landrum, Jr.; SUMTER: Russell Thomas; TELFAIR: Frank R. Mann, Sr.; THOMAS-BROOKS: Gary McKay, Rudolph Bell; TROUP: Charles T. Cowart, H. H. Hammett, Jr.; UPSON: T. A. Sappington; WARE: Leo Smith, W. L. Pomeroy; WALKER-CATOOSA-DADE: Fred H. Simonton, Howard C. Derrick; WARREN: H. B. Cason; WASHINGTON: Joseph E. Lever; WAYNE: R. A. Pumpelly; WHITFIELD: David Wells; WILKES: Harry L. Cheves, Sr.

County medical societies not represented at this session of the House of Delegates were as follows:

BARTOW, BLUE RIDGE, BULLOCH-CANDLER-EVANS, DECATUR-SEMINOLE, GRADY, HABERSHAM, LAMAR, MITCHELL, PEACH BELT, RANDOLPH-TERRELL, SOUTHEAST, STEPHENS, TAYLOR, TIFT, TRI-COUNTY, WALTON, and WORTH.

Reference Committees

Speaker Goodwin then appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE NO. 1: W. P. Rhyne, Albany, Chairman; William Coleman, Hawkinsville, Secretary; Harold P. McDonald, Atlanta; Julian Neal, Jr., Macon; W. L. Pomeroy, Waycross; Brue D. Burleigh, Marietta; and F. M. Parks, Carrollton.

REFERENCE COMMITTEE NO. 2: A. J. Waters, Augusta, Chairman; Henry Jennings, Gainesville, Secretary. Robert Gibbs, Decatur; Ruskin King, Savannah; Ralph Roberts, Fitzgerald; Rudolph Bell, Thomasville; and Lamar Peacock, Atlanta.

REFERENCE COMMITTEE NO. 3: T. A. Peterson, Savannah, Chairman; Howard C. Derrick, LaFayette, Secretary; Willis P. Jordan, Columbus; Ralph Davis, Rome; Hugh Hailey, Atlanta; P. T. Scoggins, Commerce; Don Schmidt, Cedartown, R. J. Moye, Swainsboro; and John M. McCoy, Atlanta.

REFERENCE COMMITTEE NO. 4: Charles McArthur, Cordele, Chairman; Rudolph Jones, Macon, Secretary; Marvin Greene, Monticello; W. A. Fuller, Augusta, W. H.

Fulmer, Savannah; John P. Tucker, Moultrie; Jack Landham, Griffin; J. A. Green, Athens; C. J. Roper, Jasper; and Mark Dougherty, Atlanta.

REFERENCE COMMITTEE NO. 5: Major Fowler, Atlanta, Chairman; Leo Smith, Waycross, Secretary; Lester Rumble, Atlanta; E. C. McMillan, Macon; Alex Little, Valdosta; Wayne Harris, Royston; and Robert McGahee, Augusta.

REFERENCE COMMITTEE NO. 6: Joseph B. Mercer, Brunswick, Chairman; S. A. Roddenbery, Columbus, Secretary; David R. Thomas, Augusta; Harry Cheves, Sr., Union Point; T. A. Sappington, Thomaston; Luther Roberts, Columbus; J. D. Martin, Atlanta; David Wells, Dalton; Rafe Banks, Gainesville; and E. G. McKay, Thomasville.

Credentials and Tellers Committees

Speaker Goodwin announced the prior appointments of the House of Delegates Credentials Committee and Tellers Committee as follows:

Credentials Committee: Eustace A. Allen, Atlanta, Chairman; Milford Hatcher, Macon; and William Harbin, Rome.

Tellers Committee: C. H. Richardson, Sr., Macon, Chairman; C. L. Ayers, Toccoa; and H. Dawson Allen, Milledgeville.

Approval of 1958 Minutes

To expedite the reading and adoption of the minutes of the 1958 Session of the House of Delegates held in conjunction with the *104th Annual Session of the Medical Association of Georgia meeting in Macon, April 27-30, 1958, the Chair entertained a motion that the minutes as published in the June, 1958 issue of the *Journal of the Medical Association of Georgia* be approved. It was duly moved and seconded that this motion be approved.

Memorial Service

Speaker Goodwin then introduced the Rev. Charles F. Schilling of St. Paul's Episcopal Church, Augusta, Georgia who conducted the Memorial Service for the members deceased during the past year. After the prayer, Speaker Goodwin called the names of the departed colleagues:

CHARLES C. ADAMS, Atlanta, April 17, 1959
H. A. BARREN, Thomaston, November 16, 1958
W. C. BLANDFORD, Atlanta, December 2, 1958
JAMES N. BRAUNER, Atlanta, March 8, 1959
THOMAS P. BROWN, Thomasville, February 22, 1959
WILLIAM W. BRYAN, Atlanta, April 10, 1958
J. F. CHISHOLM, Savannah, December 13, 1958
VIRGIL C. COOKE, Savannah, November 10, 1958
WALTER G. CRAWLEY, Marietta, March 22, 1958
B. B. DAVIS, Gainesville, March 17, 1959
HAL M. DAVISON, Atlanta, April 26, 1958
JAMES B. DILLARD, Davisboro, November 18, 1958
DAN C. ELKIN, Lancaster, Ky., November 3, 1958
M. J. EPTING, Savannah, May 8, 1958
JOHN B. FITTS, Atlanta, March 5, 1958
D. A. FORRER, Griffin, August 13, 1958
C. C. GIDDENS, Valdosta, February 17, 1958
CLAUDE GRIFFIN, Atlanta, May 8, 1958
G. T. HARPER, Dewey Rose, September 29, 1958
M. M. HEAD, Zebulon, March 31, 1959
ARMENIOUS C. HOBBS, JR., Columbus, May 9, 1959
J. E. JOHNSON, JR., Elberton, October 30, 1958
O. D. KING, Bremen, May 15, 1958
W. E. LIPSCOMB, Cumming, April 26, 1959
MORRIS J. KUSNITZ, JR., Alamo, September 7, 1958

R. N. LITTLE, Summerville, December 2, 1958
I. M. LUCAS, Albany, April 3, 1958
W. H. LUCAS, Cedartown, March 25, 1958
E. S. MARKS, Marietta
J. M. McELVEEN, Brooklet, November 23, 1958
H. M. MICHEL, Augusta, May 25, 1958
D. S. MIDDLETON, Rising Fawn, February 8, 1959
B. H. MINCHEW, Waycross, September 14, 1958
J. H. MULL, Rome, September 21, 1958
FRANCIS X. MULHERIN, Augusta, March 14, 1959
HAL C. MILLER, Atlanta, February 21, 1959
RICHARD M. NELSON, Atlanta, February 6, 1958
RALPH G. NEWTON, Macon, June 5, 1958
T. E. ODEN, Blackshear, February 9, 1958
F. O. PEARSON, Macon, January 8, 1959
B. F. RILEY, JR., Thomson, November 11, 1958
C. L. ROLES, Camilla, February 23, 1958
J. F. SCHNEIDER, February 9, 1958
W. J. SCHNEIDER, Folkston, April 19, 1958
H. F. SHIELDS, Chickamauga, May 8, 1959
J. W. STANFORD, Cartersville, February 23, 1958
W. E. THOMASSON, Carrollton, June 30, 1958
CLEVELAND THOMPSON, Waynesboro, August 5, 1958
H. L. TREUSCH, Washington, D. C., March 27, 1958
W. A. WALKER, Cairo, February 20, 1958
J. B. WARNELL, Cairo, March 12, 1959
J. CALVIN WEAVER, Atlanta, April 20, 1958
A. J. WHELCHER, Cordele, December 15, 1958
EDWARD O. WHITE, Madison, June 18, 1958
L. W. WILLIAMS, Savannah, January 28, 1959

Annual Reports

Speaker Goodwin called for the annual reports of officers, council, councilors, and committees as the next item of business. (A cross reference of the reports of officers, council, councilors and committees, and allied reports as introduced at this session is listed below with the Reference Committee to which the report was referred. The full report and action by the Reference Committee and the House of Delegates is listed under the proceedings of the Second Session of the House of Delegates. See pages 312-362.)

REPORTS OF OFFICERS

President — Lee Howard, Sr., Savannah — Reference Committee No. 1—See Page 313.
President-Elect—Luther H. Wolff, Columbus—Reference Committee No. 1—See Page 313.
Immediate Past President—W. Bruce Schaefer, Toccoa —Reference Committee No. 1—See Page 314.
First Vice President—George Alexander, Forsyth—Reference Committee No. 2—See Page 337.
Second Vice President—Charles W. Hock, Augusta—Reference Committee No. 2—See Page 337.
Secretary—Chris J. McLoughlin, Atlanta—Reference Committee No. 2—See Page 338.
Treasurer—Chris J. McLoughlin, Atlanta—Reference Committee No. 2—See Page 339.
AMA Delegates — C. H. Richardson, Sr., Macon; Eustace A. Allen, Atlanta; Henry H. Tift, Macon—Reference Committee No. 1—See Page 314.
Speaker of the House—Thomas W. Goodwin, Augusta —Reference Committee No. 3—See Page 327.

REPORT OF COUNCIL

Report of Council—George R. Dillinger, Chairman, Thomasville—Reference Committee No. 3—See Page 328.

REPORTS OF COUNCILORS AND VICE-COUNCILORS

First District Councilor and Vice-Councilor—Charles T. Brown, Guyton and T. A. Peterson, Savannah—Reference Committee No. 4—See Page 347.

Second District Councilor and Vice-Councilor—George R. Dillinger, Thomasville and J. Z. McDaniel, Albany—Reference Committee No. 4—See Page 347.

Third District Councilor and Vice-Councilor—W. G. Elliott, Cuthbert and Willis P. Jordan, Columbus—Reference Committee No. 4—See Page 348.

Fourth District Councilor and Vice-Councilor—Virgil Williams, Griffin and George P. Kinnard, Newnan—Reference Committee No. 5—See Page 353.

Fifth District Councilor and Vice-Councilor—J. G. McDaniel, Atlanta and Charles S. Jones, Atlanta—Reference Committee No. 5—See Page 353.

Sixth District Councilor and Vice-Councilor—Henry H. Tift, Macon and George H. Alexander, Forsyth—Reference Committee No. 5—See Page 353.

Seventh District Councilor and Vice-Councilor—D. Lloyd Wood, Dalton and Ralph W. Fowler, Marietta—Reference Committee No. 1—See Page 315.

Eighth District Councilor and Vice-Councilor—F. G. Eldridge, Valdosta and James M. Hicks, Brunswick—Reference Committee No. 1—See Page 315.

Ninth District Councilor and Vice-Councilor—C. R. Andrews, Canton and Paul T. Scoggins, Commerce—Reference Committee No. 1—See Page 316.

Tenth District Councilor and Vice-Councilor—Addison Simpson, Jr., Washington and David R. Thomas, Augusta—Reference Committee No. 2—See Page 342.

REPORTS OF COMMITTEES

Cancer—Everett L. Bishop, Atlanta, Chairman—Reference Committee No. 2—See Page 342.

Constitution and Bylaws—Thomas W. Goodwin, Augusta, Chairman—Reference Committee No. 6—See Page 324.

Geriatrics—Harry Brill, Columbus, Chairman—Reference Committee No. 4—See Page 349.

History and Vital Statistics—Carl C. Aven, Marietta, Chairman—Reference Committee No. 4—See Page 349.

Hospital Relations—Milford B. Hatcher, Macon, Chairman—Reference Committee No. 5—See Page 354.

Industrial Health—T. A. Peterson, Savannah, Chairman—Reference Committee No. 5—See Page 355.

C. W. Long Memorial—Lester Rumble, Jr., Atlanta, Chairman—Reference Committee No. 2—See Page 344.

Insurance and Economics—David R. Thomas, Jr., Augusta, Chairman—Reference Committee No. 4—See Page 349.

Maternal and Infant Welfare—Eugene Griffin, Atlanta, Chairman—Reference Committee No. 5—See Page 355.

Medical Defense—Charles S. Jones, Atlanta, Chairman—Reference Committee No. 4—See Page 350.

Medical Education—Charles S. Stone, Atlanta, Chairman—Reference Committee No. 5—See Page 355.

Legislation—J. Frank Walker, Atlanta, Chairman—Reference Committee No. 5—See Page 359.

Professional Conduct—W. F. Reavis, Waycross, Chairman—Reference Committee No. 4—See Page 351.

Veterans Affairs—C. R. Andrews, Canton, Chairman—Reference Committee No. 5—See Page 356.

Woman's Auxiliary Advisory—Virgil B. Williams, Griffin, Chairman—Reference Committee No. 1—See Page 316.

Public Health—H. J. Bickerstaff, Columbus, Chairman—Reference Committee No. 3—See Page 332.

Public Service—John P. Heard, Decatur, Chairman—Reference Committee No. 2—See Page 344.

Rural Health—Albert Morris, Fairburn, Chairman—Reference Committee No. 5—See Page 356.

Scientific Exhibit Awards—Ted F. Leigh, Atlanta, Chairman—Reference Committee No. 1—See Page 316.

Mental Health—Rives Chalmers, Atlanta, Chairman—Reference Committee No. 3—See Page 334.

Blood Banks—Lester Forbes, Atlanta, Chairman—Reference Committee No. 4—See Page 351.

Crippled Children—Jack C. Hughston, Columbus, Chairman—Reference Committee No. 1—See Page 317.

Medical Civil Preparedness—Edgar M. Dunstan, Atlanta, Chairman—Reference Committee No. 2—See Page 345.

Ministerial Liaison—Needham B. Bateman, Atlanta, Chairman—Reference Committee No. 5—See Page 358.

Physician—Lawyer Liaison—W. Bruce Schaefer, Toccoa, Chairman—Reference Committee No. 1—See Page 320.

AMEF—George Nicholson, Cornelia, Chairman—Reference Committee No. 2—See Page 345.

Radiologic Safety—Robert M. Tankesley, Atlanta, Chairman—Reference Committee No. 3—See Page 333.

School Child Health—Grady Black, Griffin, Chairman—Reference Committee No. 4—See Page 351.

VFW Liaison—W. Bruce Schaefer, Toccoa, Chairman—Reference Committee No. 5—See Page 359.

Weekly Health Column—Howard C. Derrick, LaFayette, Chairman—Reference Committee No. 2—See Page 346.

ALLIED REPORTS

Headquarters Office—Messrs. Milton D. Krueger and John F. Kiser, Atlanta—Reference Committee No. 3—See Page 333.

Journal of the Medical Association of Georgia—Edgar Woody, Jr., and Miss Anne Whiddon, Atlanta—Reference Committee No. 1—See Page 317.

Woman's Auxiliary to the Medical Association of Georgia—Mrs. Luther H. Wolff, Columbus, President—Reference Committee No. 1—See Page 318.

General Practitioner of the Year Award

Speaker Goodwin called on Chairman of Council George R. Dillinger to present nominations received by Council for the "1959 Georgia General Practitioner of the Year Award." The following names were presented in nomination: J. Rufus Evans, Decatur, nominated by the DeKalb County Medical Society; Jack Guy Standifer, Blakely, nominated by the Southwest Georgia Medical Society; Claude W. Harvey, Hogansville, nominated by Troup County Medical Society; J. C. Logan, Plains, nominated by the Sumter County Medical Society; and W. J. Hutchins, Buford, nominated by the Chattahoochee

Medical Society. Speaker Goodwin then called for nominations from the floor and there being none, he requested that a vote by secret ballot be taken by the House Tellers Committee. Tellers Committee Chairman Charles Richardson, Sr. announced the following results: J. C. Logan, Plains, elected "1959 Georgia General Practitioner of the Year."

Hardman Award

Speaker Goodwin called on President Lee Howard, Sr. to present nominations received by the Council of the Medical Association of Georgia for the Lamartine Hardman Award. President Howard presented the nominations of Robert Connor Pendergrass, Americus, nominated by the Southwest Georgia Medical Society and Edgar Rudolph Pund, Augusta, nominated by the Richmond County Medical Society. Speaker Goodwin then requested that a vote of the House be taken by secret ballot. Tellers Committee Chairman Charles Richardson, Sr. then announced the following results: Edgar Rudolph Pund, Augusta elected the 1959 recipient of the "Hardman Award."

Unfinished Business

Speaker Goodwin called on Mr. Earl Hathcock, Augusta, member of the Executive Council of the Student American Medical Association and regional President of the SAMA for Southeastern states. Mr. Hathcock reported on the progress and activity of the Student American Medical Association. He cordially thanked the Medical Association of Georgia for its support of the two chapters in Georgia. Speaker Goodwin recognized Corbett Thigpen, Augusta, who spoke on the excellence and importance of the SAMA activity.

Supplementary Reports

Speaker Goodwin then called for Supplementary Reports which were introduced in the following order:

Council Supplementary Report No. A: Milledgeville Committee Report—George R. Dillinger, Thomasville, Chairman—Reference Committee No. 3—See Page 335.

Rural Health Committee Supplementary Report No. B: Clarkesville Laboratory School—Albert Morris, Fairburn, Chairman—Reference Committee No. 5—See Page 357.

Council Supplementary Report No. C: MAG Headquarters Office Building—George R. Dillinger, Thomasville, Chairman—Reference Committee No. 3—See Page 335.

Council Supplementary Report No. D: Social Security—George R. Dillinger, Thomasville, Chairman—Reference Committee No. 3—See Page 336.

Secretary Supplementary Report No. E: Addendum Report of the Secretary—Chris J. McLoughlin, At-

lanta, Secretary—Treasurer—Reference Committee No. 6—See Page 322.

Speaker Goodwin then recognized John Elliott, Savannah, who presented a special resolution re: Caroline J. Williams, M.D. The Resolution reads as follows:

"WHEREAS, Caroline J. Williams, M. D., of Savannah, has been an outstanding civic leader having served as a member of the Board of Directors of the Georgia Heart Association, Medical Director of the Savannah TB Sanitarium, adviser on rehabilitation services for Chatham County, and has been active in the field of mental health, and

WHEREAS, Dr. Williams has made an outstanding contribution to her community by serving as a speaker on health and medical subjects to PTA groups, civic clubs, and other organizations, and

WHEREAS, recently Dr. Williams was recognized as 'Mother of the Year' in Savannah,

NOW THEREFORE BE IT RESOLVED that her activities reflect credit upon the medical profession of Georgia,

AND BE IT FURTHER RESOLVED, that the House of Delegates hereby commends Dr. Caroline J. Williams for her exceptional accomplishments,

AND BE IT FURTHER RESOLVED that Dr. Williams be notified of this action of the House of Delegates."

Speaker Goodwin ruled that as this Resolution was not of a controversial nature that he would entertain a motion that the House act as a Committee of the whole in approving this Resolution. On motion duly made and seconded the Special Resolution Re: Caroline J. Williams, M.D., was so approved.

RESOLUTIONS

Resolution No. 1—Standardized Insurance Form—Walker-Catoosa-Dade Medical Society—Reference Committee No. 3—See Page 336.

Resolution No. 2—Keogh-Simpson Bill—Fulton County Medical Society—Reference Committee No. 5—See Page 360.

Resolution No. 3—Compulsory Social Security—Muscogee County Medical Society—Reference Committee No. 3—See Page 336.

Resolution No. 4.—Positive Medical Legislation—Spalding County Medical Society—Reference Committee No. 5—See Page 361.

Resolution No. 5—Auto Safety—Spalding County Medical Society—Reference Committee No. 2—See Page 346.

Resolution No. 6—Release of Information—Southwest Georgia Medical Society—Reference Committee No. 4—See Page 352.

Resolution No. 7—Industrial Insurance Form—Southwest Georgia Medical Society—Reference Committee No. 4—See Page 352.

Resolution No. 8—Tax Exempt Status—Fulton County Medical Society—Reference Committee No. 5—See Page 360.

Resolution No. 9—Non Licensed Practitioners—Flint Medical Society—Reference Committee No. 5—See Page 361.

Resolution No. 10—Sterilization—Flint County Medical Society—Reference Committee No. 5—See Page 361.

Resolution No. 11—Committee Membership—Glynn County Medical Society—Reference Committee No. 6—See Page 327.

Resolution No. 12—Committee on Medicare—Glynn County Medical Society—Reference Committee No. 3—See Page 336.

Resolution No. 13—Hospitalization Fund—Ware County Medical Society—Reference Committee No. 1—See Page 320.

Resolution No. 14—MD License Plates—Carroll-Douglas-Haralson Medical Society—Reference Committee No. 5—See Page 361.

Resolution No. 15—Charges of Unethical Conduct—Baldwin County Medical Society—Reference Committee No. 3—See Page 336.

Resolution No. 16—Stroke Programs—E. C. McMillan, Bibb County Medical Society—Reference Committee No. 1—See Page 321.

Resolution No. 17—Board of Medical Examiners—J. H. Robinson, Sumter County Medical Society—Reference Committee No. 5—See Page 362.

Resolution No. 18—Automobile Accidents—Hall County Medical Society—Reference Committee No. 2—See Page 347.

Resolution No. 19—Support Mental Health—Walker-Catoosa-Dade Medical Society—Reference Committee No. 3—See Page 337.

Speaker Goodwin called for other items of new business and there being none on motion duly made and seconded the First Session of the House of Delegates was recessed at 6:30 P.M.

SECOND SESSION, HOUSE OF DELEGATES

(Recessed)

Wednesday, May 20, 1959

THE SECOND SESSION (Recessed) of the House of Delegates of the Medical Association of Georgia held in conjunction with the *105th Annual Session of the Association was called to order by Speaker of the House Thomas W. Goodwin of Augusta at 9:10 A.M., May 20, 1959 in the Crystal Room, Bon Air Hotel, Augusta, Georgia.

Speaker Goodwin called on Credentials Committee Chairman Eustace A. Allen for a preliminary report of delegates in attendance. Dr. Allen reported that more than 40 of the registered members of the House were present. Speaker Goodwin then declared a quorum present and accounted for and that the House was in session. Dr. Allen later made the following complete report on attendance.

Attendance

In a compilation of attendance taken from the official roll, 39 county medical societies were represented by their duly elected delegates or alternates. Thirty-four county medical societies had no representatives at the Second Session. Of a total of 139 authorized delegates from their respective county medical societies, the official roll showed 77 delegates present at this Second Session.

BALDWIN: Zeb L. Burrell, Jr., Melvin E. Smith; BEN HILL-IRWIN: Ralph D. Roberts; BIBB: Mil-

ford B. Hatcher, Rudolph Jones, E. C. McMillan; CARROLL-DOUGLAS-HARALSON: R. L. Denny; Francis M. Parks; CHATTAHOOCHEE: Marcus Mashburn; CHATTOOGA: W. P. Martin; CHEROKEE-PICKENS: C. J. Roper; COBB: W. C. Mitchell; COFFEE: Horace G. Joiner; CRAWFORD W. LONG: J. A. Green, R. H. Randolph; DEKALB: R. I. Gibbs, Jr., Floyd R. Sanders, M. Freeman Simmons, L. M. Vinton, Jr.; EMANUEL: R. J. Moye; FLINT: Chas. E. McArthur; FRANKLIN-HART-ELBERT: W. W. Harris; FULTON: John S. Atwater, Helen Bellhouse, William Coles, Major F. Fowler, E. L. Graydon, I. L. Greenburg, Mason D. Lowance, John M. McCoy, Harold P. McDonald, Lester Rumble, Jr., B. L. Shackelford, Exum Walker, Henry E. Steadman; GEORGIA MEDICAL SOCIETY: John L. Elliott, William H. Fulmer, Ruskin King, T. A. Peterson; GLYNN: Joseph B. Mercer, C. A. Wilson, Jr.; GORDON: L. R. Lang; HABERSHAM: J. J. Arrendale; HALL: Rafe Banks, Jr., Henry S. Jennings, Jr.; JACKSON-BARROW: Paul T. Scoggins; JASPER: Marvin L. Greene; JENKINS: A. P. Mulkey; LAURENS: Wm. A. Dodd; MUSCOGEE: W. P. Jordan, Luther J. Roberts, S. A. Roddenbery, Charles R. Smith; NEWTON-ROCKDALE: J. C. Brown; OCMULGEE: W. E. Coleman. PEACH BELT: Frank Vinson; RABUN: G. H. Boyd, Jr.; RICHMOND: A. M. Battey, W. A. Fuller, Gordon M. Kelly, R. C. McGahee, David R. Thomas, Jr., A. J. Waters; SOUTHWEST GEORGIA: James B. Martin; SPALDING: Jack Landham, Jr., Virgil Williams; STEPHENS: C. L. Ayers; SUMTER: John H. Robin-

son; TELFAIR: F. R. Mann, Sr.; TROUP: Charles Cowart, H. Hilt Hammett, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: H. C. Derrick, Jr., Fred Simonton; WARE: W. C. Pomeroy, Leo Smith.

County medical societies not represented at this Second Session of the House of Delegates are as follows:

ALTAMAHA, BARTOW, BLUE RIDGE, BULLOCH-CANDLER-EVANS, BURKE, CLAYTON-FAYETTE, COLQUITT, COWETA, DECATUR-SEMINOLE, DOUGHERTY, FLOYD, GRADY, JEFFERSON, LAMAR, McDUFFIE, MERIWETHER-HARRIS, MITCHELL, OCONEE VALLEY, POLK, RANDOLPH-TERRELL, SCREVEN, SOUTH GEORGIA, SOUTHEAST GEORGIA, TAYLOR, THOMAS-BROOKS, TIFT, TRI-COUNTY, WALTON, WARREN, WASHINGTON, WAYNE, WHITFIELD, WILKES, WORTH.

Reports of References Committees

Speaker Goodwin called on the Chairman of the Reference Committees to present their reports for action by the House of Delegates at this Second Session.

Report of Reference Committee No. 1

W. P. Rhyne, M.D., Chairman

(The following reports as presented to this reference committee are printed in full with the reference committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 1 met at 8:00 A.M. on May 18, 1959 in the Card Room, Bon Air Hotel, Augusta, Georgia. Members present were: W. P. Rhyne, Albany, Chairman; William Coleman, Hawkinsville, Secretary; Harold P. McDonald, Atlanta; Jule Neal, Jr., Macon; W. L. Pomeroy, Waycross; Bruce D. Burleigh, Marietta; and F. M. Parks, Carrollton.

President

LEE HOWARD, SR., M.D., Savannah

Space will not permit an enumeration of the year's activities which appear in the Handbook elsewhere. This past year has been one of increasing activity, especially in the Headquarters office. In spite of employing Mrs. Grinalds several months ago, the office force has been working under considerable pressure, and overtime some days, in order to finish the increasing load of work within the day.

Soon after I assumed office, I found that the correspondence coming to my office in Savannah was considerable and I proceeded to have a very nice desk, a chair, and files installed in the Headquarters office which I shared with the secretary. This was done with the approval of Council and I think the setup will be very helpful to the incoming president.

Looking to the future, our main objective should be new suitable quarters with an office for the president, which is not now available, and there is also a great

need for storage space which is definitely now inadequate. With the raise in dues, it is now possible to put a considerable amount into the Building Fund each year and I think the general membership should be apprised of this fact and need.

In spite of the marked increase in activity and achievement, this year has been a tranquil and happy one compared with the preceding three years. There has also been a considerable saving in attorney's fees expended. I have been impressed with the continued dedication and hard work of your Council and Committees. Attendance has been almost 100 per cent at all meetings, some of which have lasted from eight to 12 hours.

The past year has been a busy one for the president but it is hoped that some of the many objectives have been reached.

REFERENCE COMMITTEE RECOMMENDATION—The President is to be commended on his very concise and complete report which is unanimously approved.

HOUSE OF DELEGATES ACTION—Adopted the President's Report as recommended by the Reference Committee on motion duly made and seconded.

President-Elect

LUTHER H. WOLFF, M.D., Columbus

The framers of the Constitution and Bylaws of the Medical Association of Georgia wisely foresaw the need of a period of preparation and orientation for the President-elect of the Medical Association of Georgia, and provided that the President-elect should have a year of such instruction before taking office.

Primarily, the President-elect becomes informed by serving on the Council and the Executive Committee of the Council. During this year he comes to grips with many ramifications and problems besetting our present day medical organizations.

The present President-elect has attended all Council and Executive Committee meetings during the past year, except the June, 1958 meetings, when he was attending the American Medical Association meeting in San Francisco.

The principal secondary duty of the President-elect is to assist the President by representing the President whenever such assistance is requested.

The President-Elect has represented the Medical Association of Georgia at the Board Meeting of the Woman's Auxiliary to the Medical Association of Georgia, which was held at Ida Cason Calloway Garden on June 12-13, 1958. The President-Elect substituted for the President at meetings of the Third District Medical Society which were held in May, 1958 at Lake Blackshear, at Cordele, Georgia, and on October 23, 1958, in Columbus, Georgia. He also represented the President at the dedication of the new Medical Clinic held at Rochelle, Georgia, on October 1, 1958.

The President-Elect wishes to commend the Officers, Councilors, and the Staff of the Medical Association of Georgia for the sincerity and earnestness of purpose demonstrated during the past year. He sincerely hopes that the coming year will be equally as fruitful.

REFERENCE COMMITTEE RECOMMENDATION—The report of the President-Elect is commended and approved.

HOUSE OF DELEGATES ACTION—Adopted the President-Elect's report as recommended by the Reference Committee on motion duly made and seconded.

Immediate Past President

W. BRUCE SCHAEFER, M.D., Toccoa

The Immediate Past President has been very active this year with commitments, which were made during the year as President.

He has attended as many Council meetings and Executive Council meetings as possible. He has had to be away from several, however, but he has served as chairman of the Liaison Committee of the Talmadge Memorial Hospital, and wishes to report that it is progressing satisfactorily, and in harmony with Richmond County Medical Society. He has also served as chairman of the Milledgeville Investigation Committee. He has been in direct contact with the Headquarters Office all during the year, and has given what assistance he could.

There is one recommendation that The Immediate Past President would like to make to the House of Delegates, and that is, that several years ago, the Council began to have their meetings out over the State in order to bring the affairs of Council closer to the membership in the grass roots. This has taken on quite a great deal of momentum, up until now that nearly every Council meeting is held outside of Atlanta. This entails an extra expense on the Association, and some of these meetings are being held at the distal end of the State, and sometimes it runs from \$300.00 to \$400.00 extra expense to take the Headquarters Staff to the meetings.

It is a recommendation of the Immediate Past President that every other Council Meeting should be held in Atlanta, and that no meeting should be held in any one district over once every two years.

This would enable the Council to visit all of the districts without such an additional expense to the Association. This cannot be decided by the Council, as they cannot commit themselves from one year to the next, and I think it is a commitment that should come from the House of Delegates.

I have enjoyed serving as Immediate Past President, and I think that our organization is progressing satisfactorily, and we hope that soon we will be in a new home.

REFERENCE COMMITTEE RECOMMENDATION—The Report of the Immediate Past President is commended and approved. Exception is taken to the recommendation as to the location of Council meetings, and this Committee recommends that Council use its own judgment as to time and locations of meetings. No Council can bind any succeeding Council as to its action.

HOUSE OF DELEGATES ACTION—Adopted the report of the Immediate Past President as amended by the Reference Committee on motion duly made and seconded.

AMA Delegates

C. H. RICHARDSON, SR., M.D., Macon; EUSTACE A. ALLEN, M.D., Atlanta; and HENRY H. TIFT, M.D., Macon

Everything changes. There is no better demonstration than the rapid changes in medicine. Once we felt that if we did our best in looking after the health of the people and in attending to our professional business our task was complete. Now we realize how wrong we were. We became aware that there was more to the practice of medicine. We failed to tell the people about our activities; our desire to improve the health of the nation. It is essential that we take a more

active interest in the affairs of our community. Speaking to the House of Delegates, Dr. Gunnar Gundersen, president of the American Medical Association, called upon the medical profession to exert leadership and imagination in meeting the problems of these changing times. He urged positive action to solve our mediocconomic situation. The American Medical Association is undergoing reorganization to meet the changing trend. Many policies are being referred to the constituent medical societies for their evaluation and decisions. If we accept this responsibility, more decisions on National problems will come our way. Dr. Gundersen declared that the time has passed for policies to be based on generalities, platitudes, and flag-waving. A more active program is essential. The reorganization of the A.M.A. is already exerting a more positive approach to our problems. One of the first moves and a very valuable one was the establishing of the *A.M.A. News*, a bi-weekly newspaper, being sent to all members, bringing them up to date on the thinking and activities in the various medical fields. The first issue came out in September 1958. Be sure to read every issue.

On Monday, June 23, 1958, the 107th annual convention got under way in San Francisco with an estimated registration of 14,000 physicians. There were 60 resolutions referred to ten reference committees covering all phases of medical problems. Among these were resolutions on the United Mine Workers' Welfare and Retirement Fund, Social Security coverage, voluntary health organizations, Veteran's Medical Care, Medicare Program, etc.

Dr. Louis M. Orr of Orlando, Florida, a graduate of Emory University School of Medicine, was unanimously elected president-elect for the coming year. Dr. Virgil P. Sydenstricker, professor emeritus of medicine at the Medical College of Georgia, received the seventh Goldberger Award in clinical nutrition. The 1958 Distinguished Service Award went to Dr. Frank H. Krussen, professor of physical medicine and rehabilitation at Mayo Foundation.

The House of Delegates of A.M.A. condemned "Over the Counter" medication and joined with other interested groups coordinated by The National Better Business Bureau seeking to eliminate objectionable advertising of over the counter medicines. The A.M.A. became a sustaining member of the National Better Business Bureau. They approved a National Interprofessional Code for physicians and lawyers prepared by a joint liaison committee of the A.M.A. and A.B.A.

After many years of faithful service Dr. George F. Lull retired as secretary of the Association.

Dr. Gunnar Gundersen was duly inaugurated to the presidency on Tuesday evening. He succeeded Dr. David Allman of Atlantic City.

Reverend Billy Graham spoke to the Christian Medical Society at a luncheon on Monday 23rd.

Representative Oren Harris of Arkansas addressed the officers and delegates to the A.M.A. at a breakfast given by the Arkansas Medical Society on Monday 23rd.

The twelfth clinical meeting of A.M.A. was held in Minneapolis, Minnesota on December 2nd to 5th, 1958, with 3,000 physicians in attendance. Dr. Gundersen opened the House of Delegates meeting with a speech urging vision on several major issues. He told the

delegates to learn from past experiences but plan for the future. He said that medicine must fight hard to preserve the basic principles and traditions essential to good medical care, but also be alert and adaptable to the changing times.

A 68 year old physician, Dr. Lonnie A. Coffin, of Farmington, Iowa was selected as the General Practitioner of the year.

The American Medical Education Foundation received checks totaling \$248,658.75 from six State Medical Societies.

Governor Orville Freeman speaking before the House of Delegates appealed to the medical profession for adequate medical care plan for the aged. He referred to the Forand Bill before Congress which would provide hospital and medical benefits. He said it may not be a complete solution or the best solution. It may not be acceptable to the medical profession. He also said the medical profession has a right to oppose it but if you suppose it you also have the responsibility of helping to work out an alternative program to meet the needs that we know exist and become more serious every day. The Committee on Insurance and Prepayment Plans of A.M.A.'s Council on Medical Service feels that this can be met by voluntary health insurance or prepayment plans. Blue Shield and other groups are fostering such plans. These programs must be acceptable both to the recipient and the medical profession. Therefore, state and county medical societies must give earnest consideration to all such special programs. The Council on Medical Service is sponsoring a Buyer's Guide for physicians to help their patients to analyze the merits of available health insurance programs.

Many other subjects were considered by the House of Delegates ranging from osteopathy to Compulsory Social Security for physicians. They urged the constituent societies to study all actions of the A.M.A. and to establish committees to carry out activities on the local level.

At the San Francisco meeting one of our delegates, Charles H. Richardson, was unable to attend. His place was ably filled by his alternate J. W. Chambers of LaGrange. He made the report of the San Francisco meeting to the Council. An excellent report from which I have taken the liberty to use freely in this annual report.

The next annual meeting of the A.M.A. will be in Atlantic City, June 8th to June 12th. On June 13th to 17th, 1960 Miami, Florida will entertain the annual session for the first time. They are planning a very interesting and well rounded agenda. Georgia should be there in numbers.

REFERENCE COMMITTEE RECOMMENDATION—This Committee approved this report and commends highly its contents. This Committee goes on record as opposing the flagrant, misleading advertising of reducing pills, sleeping pills, laxatives, etc., and directs that the Public Service Committee of the MAG take appropriate action.

HOUSE OF DELEGATES ACTION—Adopted the report of the AMA delegates as recommended by the Reference Committee on motion duly made and seconded.

SEVENTH DISTRICT COUNCILOR

D. LLOYD WOOD, M.D., Dalton

The Seventh District councilor has attended all regu-

lar meetings of the Council in the past year. No matters of unusual interest have come up in the Seventh District requiring any unusual official action.

From reports over the district the quality of the medical care rendered to the patients is getting better every year.

As of December 31, 1958 over December 31, 1957 membership in the MAG had decreased by nine, while membership in the AMA had increased by seven.

Two meetings of the district society were held, the fall meeting being in Marietta with a good scientific program, and the spring meeting in Rome with an excellent program.

Counties and Secretaries	December 31, 1958		December 31, 1957	
	MAG	AMA	MAG	AMA
Bartow				
V. Hamilton Maley, Cartersville . . .	9	8	9	6
Carroll-Douglas-Haralson				
M. L. Johnson, Bowden . . .	31	23	34	18
Chattooga				
Hugh Goodwin, Summerville . . .	6	6	7	6
Cobb				
Hugh Colquitt, Marietta . . .	71	66	70	64
Floyd				
Clarence J. Sapp, Rome . . .	56	46	56	46
Gordon				
Wm. R. Thompson, Calhoun . . .	10	8	11	8
Polk				
W. H. Blanchard, Cedartown . . .	12	9	14	10
Walker-Catoosa-Dade				
E. M. Townsend, Ringgold . . .	31	21	32	22
Whitfield				
John Looper, Jr., Dalton . . .	28	21	29	21
	254	208	263	201

REFERENCE COMMITTEE RECOMMENDATION—The report of the Seventh District Councilor and Vice-Councilor is recommended approved as read but we suggest action be taken concerning MAG membership loss.

HOUSE OF DELEGATES ACTION—Adopted the report of the Seventh District Councilor and Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

EIGHTH DISTRICT COUNCILOR

F. G. ELDRIDGE, M.D., Valdosta

The various component medical societies have co-operated well this year.

One request has been submitted by physicians in Cook County and Berrien County to separate from the South Georgia Medical Society (Lowndes, Lanier, Berrien, Cook, and Echols Counties) and form a Cook-Berrien County Society. This plan has been approved pending compliance with rules and regulations of the M.A.G. Constitution and Bylaws.

<i>Counties and Secretaries</i>	<i>December 31, 1958 MAG</i>	<i>December 31, 1958 AMA</i>	<i>December 31, 1957 MAG</i>	<i>December 31, 1957 AMA</i>
Altamaha				
J. B. Brown, Jr., Baxley	8	8	6	6
Coffee				
C. S. Meeks, Douglas	13	8	15	6
Glynn				
Robert Perry, Brunswick	38	36	40	36
South Georgia				
Charles Kollar, Valdosta	51	43	50	42
Telfair				
D. B. McRae, McRae	8	6	8	6
Ware				
A. M. Knight, Jr., Waycross	50	40	49	38
Wayne				
Robert A. Pumpelly, Jessup	9	9	10	10
	<u>177</u>	<u>150</u>	<u>178</u>	<u>144</u>

REFERENCE COMMITTEE RECOMMENDATION—Your Committee recommends approval of this report and the matter concerning Cook County Medical Society be left to the discretion of Council.

HOUSE OF DELEGATES ACTION—Adopted the report of the Eighth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

NINTH DISTRICT COUNCILOR

CHARLES R. ANDREWS, M.D., Canton

The Ninth District Medical Society has been represented by the Councilor at all meetings of the administrative council of the Medical Association of Georgia and the Ninth District Society itself has had its regular meetings twice each year, April and September. These meetings are well attended and excellent scientific programs are presented each time. Interest in the Ninth District Society is high among its membership. The Ninth District continues to be strong and well organized. There have been very few problems during the last year. As will be noted the membership in the Ninth District Society has increased both statewide and nationally since 1957.

It has been a pleasure to serve as Councilor for the past year.

<i>Counties and Secretaries</i>	<i>December 31, 1958 MAG</i>	<i>December 31, 1958 AMA</i>	<i>December 31, 1957 MAG</i>	<i>December 31, 1957 AMA</i>
Blue Ridge				
Thos. J. Hicks, McCaysville	11	9	10	9
Chattahoochee				
Fayette Sims, Lawrenceville	21	16	16	12
Cherokee-Pickens				
E. A. Roper, Jasper	13	9	13	10
Habersham				
J. Lee Walker	16	15	15	14
Hall				
Hamil Murray, Gainesville	44	39	43	36

<i>Counties and Secretaries</i>	<i>December 31, 1958 MAG</i>	<i>December 31, 1958 AMA</i>	<i>December 31, 1957 MAG</i>	<i>December 31, 1957 AMA</i>
Jackson-Barrow				
A. A. Rogers, Jr., Commerce	19	11	16	11
Rabun				
J. C. Dover, Clayton	4	3	4	4
Stephens				
Ralph Chaney, Jr., Toccoa	15	12	15	12
Banks	—	—	—	—
	<u>143</u>	<u>114</u>	<u>132</u>	<u>108</u>

REFERENCE COMMITTEE RECOMMENDATION—Commended for report and the increase in membership of the MAG.

HOUSE OF DELEGATES ACTION—Adopted the report of the Ninth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Woman's Auxiliary Liaison

VIRGIL B. WILLIAMS, M.D., *Chairman*

The Advisory Committee met with The Woman's Auxiliary to The Medical Association of Georgia at their organizational meeting at Callaway Gardens. During this meeting particular encouragement was given the Auxiliary in their Nurse Recruitment Program. The Advisory Committee reviewed the proposed activities of the Auxiliary for the coming year. There were no controversial items and the program was approved.

Since that meeting members of the Advisory Committee have been consulted formally and informally on several occasions and have given advice suitable to the circumstances. The Advisory Committee has been available to the Auxiliary for consultation at all times.

The Advisory Committee wishes to express its appreciation to The Woman's Auxiliary for their untiring efforts in bettering the Medical Association of Georgia during the year 1958-59. The officers and members of The Woman's Auxiliary have exhibited an unusual interest and have displayed a high capacity for hard work in carrying out their years' program.

REFERENCE COMMITTEE RECOMMENDATIONS—Accepted with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman's Auxiliary Liaison Committee as recommended by the Reference Committee on motion duly made and seconded.

Scientific Exhibit Awards

TED F. LEIGH, M.D., *Chairman*

The Scientific Exhibit Awards Committee had a highly successful year. At the annual meeting in Macon, a large area in the auditorium was available, and was completely filled with exhibits of high caliber. In addition, for the first time, the two new illuminated exhibit boxes were used; these were purchased recently and will be used yearly hereafter in our section.

The scientific exhibits area was so placed that it was necessary to go through it in order to get to the general session meetings. This guaranteed a maximum viewing by the visiting doctors, and is a highly desirable arrangement.

There are no outstanding recommendations to be made for the year 1959-1960. Sometime in the future,

when money is available, we feel the need of purchasing two additional exhibit boxes similar to the type we now have.

REFERENCE COMMITTEE RECOMMENDATION—This Committee is to be commended for its report and fine work in setting up scientific exhibits and feels that set-ups such as in the Bon Air Hotel are better than having exhibits in walkway. This would give doctors and interested persons a better chance of viewing exhibits without interruption.

HOUSE OF DELEGATES ACTION—Adopted the report of the Scientific Exhibit Awards Committee as recommended by the Reference Committee on motion duly made and seconded.

Crippled Children

J. C. HUGHSTON, M.D., *Chairman*

The children's organizations throughout the State of Georgia have contributed another outstanding year to the progress in the care of handicapped children.

To list each organization and tell of its accomplishments is not the place of this report. Generally speaking, these organizations are working in a cooperative manner without too much duplication of effort or competition of services.

We should broaden your insight to this last statement. You are terribly aware of the many and varied organizations asking for funds for isolated types of illnesses, such as poliomyelitis, arthritis, cancer, etc. These organizations compete with one another for the donated dollar. However, they should not use these dollars to compete with one another in rendering of services, employment of unneeded technicians (physical therapist, occupational therapist, speech therapist, etc.), or construction of "workshops." If one physical therapist in a community can fulfill the need of various agencies and not be overworked, then it is a squandering of trained personnel and an unthrifty use of the donated dollar, to have two such agencies, each with a physical therapist, each therapist working only half time. These organizations should coordinate their activities so that they may make the most use of each other's personnel and facilities in all instances possible. We, as physicians on the local level, must constantly be alert to helping these organizations to live together, and must view the whole problem, and not be lured into factions. These organizations can maintain their individual personality and enthusiasm and still exist cooperatively.

Not only the donated dollar is important in this sense! So is the tax dollar. Your doctors on the Crippled Children's Division try to always use existing facilities or funds available from the voluntary organizations. Those of us working in the Crippled Children's Clinics try to contact the family physician whenever his name can be ascertained. If any of the members of the Medical Association of Georgia have any constructive criticism of our work, it would be most appreciated.

The Crippled Children's Division of the Public Health Department of Georgia has made further progress under the able and appreciated directorship of Doctor James E. Yarbrough. This has been his first full year as director, and his professional staff has been proud of the job he has accomplished.

The special divisions of care that have grown so in

the last year are the Cardiac Program, the Epileptic Program, and the Juvenile Amputee care.

The Georgia Society for Crippled Children and Adults has at least two rehabilitation centers now going full blast. The one in Albany is the older. The one in Atlanta the more recent. Various organizations can and do use these facilities. They hope to help more communities establish such centers. This Society has continued to help train technicians with their scholarships and their help in post-graduate courses. A considerable number of these technicians are now back in Georgia, and carrying on the technical work of physical therapy, occupational therapy, speech therapy, and others.

The training of these technicians, their diffusion throughout the State, and the development of these rehabilitation centers on the local level is most important. Many small and local "work centers" under good development and guidance of the county medical society members will rehabilitate many more Georgians than one large centrally located center. Communities realize this; thus, their concern in trying to develop these facilities.

We are still hopeful of working out a cooperative program with the duPont Nemours Foundation which helps in other states and which has offered to help in Georgia as soon as we can more definitely coordinate the activities of the many varied organizations interested in the care of the handicapped child.

Allow me to speak in behalf of your physicians (other than myself) working with the handicapped child and say to you, they have put in another outstanding year of progress and that the quality of care cannot be exceeded in any other state.

REFERENCE COMMITTEE RECOMMENDATION—Approved and the work of this Committee was highly commended.

HOUSE OF DELEGATES ACTION—Adopted the report of the Crippled Children's Committee as recommended by the Reference Committee on motion duly made and seconded.

Journal of the Medical Association of Georgia

EDGAR WOODY, JR., M.D., *Editor*

The 1958-59 report of the *Journal of the Medical Association of Georgia* is submitted herewith:

PERSONNEL—Miss Helen L. Hendry, Managing Editor of the *Journal* submitted her resignation in June of 1958. Miss Hendry was with the *Journal* for one year and contributed much to its improvement. Miss Elaine H. Ryals, a graduate of Valdosta State College and a native of McRae, replaced Miss Hendry in June of 1958. Although Miss Ryals was with the *Journal* for only eight months, having resigned in January of 1959 to get married, she proved herself as a very able Managing Editor. Most of the recent changes in the *Journal* were under her direction. The vacancy made by the departure of Miss Ryals was filled by another native of McRae, Miss Anne G. Whiddon, a 1958 graduate of the University of Georgia.

There have been no changes in the staff of Contributing Editors. Our active contributors are as follows: Herbert S. Alden, Atlanta; Thomas Findley, Augusta; J. Willis Hurst, Atlanta; Charles S. Jones, Atlanta; Arthur M. Knight, Waycross; Arthur J. Merrill, Atlanta; Lester Rumble, Jr., Atlanta; Peter L. Scardino, Savannah; Patrick C. Shea, Jr., Atlanta; and Robert

H. Vaughan, Columbus. These contributing editors have been increasingly active in the past year and are responsible for all contributions made in our new feature, "Current Clinical Concepts."

CONFERENCE—In October 1958 the second South-eastern Region State Medical Journal Conference was held in Austin, Texas. This meeting was sponsored by the Texas State Medical Association in their beautiful headquarters' building. The first of this series of meetings was begun by the Medical Association of Georgia in Atlanta in the fall of 1956. From the attendance and enthusiasm shown at the Texas meeting it would appear that this series will continue on a regular basis every other year. *The Journal of the Medical Association of Georgia* was represented by the Editor, and the Managing Editor, Miss Ryals. The Editor was one of those participating in the program. The two-day conference was especially beneficial to Miss Ryals as she had just recently assumed her new duties.

APPOINTMENT—At the meeting of the State Medical Journal Advertising Bureau held at the American Medical Association's Annual Session in San Francisco, Edgar Woody, Jr., was elected to its Board of Directors.

CONTENT—There have been several changes in the content of the *Journal* over the past year but no drastic departure from the norm.

The *Journal* has continued with its increased amount of scientific articles, which average about six per month. This was necessary to balance editorial matter with the increased advertising.

The special feature pages such as the Heart Page and the President's Letter have continued. The Cancer Page has been reinstituted along with a new feature, Current Clinical Concepts. This new feature includes short bits of clinical information gathered by the Contributing Editors.

There have been no changes in the Physicians' Bookshelf and Abstracts by Georgia Authors. The contents page continues to remain the same.

The publication of Medical Grand Rounds, from the Medical College of Georgia and Emory University on several occasions during the past year has evoked considerable reader interest and enthusiasm.

FORMAT AND TYPOGRAPHY—Under the direction of John S. McKenzie, Higgins-McArthur Printing Company, the *Journal* has undergone many improvements in overall appearance.

Headings on the feature departments (Physicians' Bookshelf, Abstracts, Cancer Page, Heart Page, President's Letter, etc.) have been restyled using a vertical down rule design. The President's Letter has been made to look more like a letter, using the president's own signature in signing. The president's picture has also been added to this page. The official heart emblem has been reinstituted on the Heart Page at the request of the Georgia Heart Association.

On the cover there has been one major change. The flag has been made smaller and may be placed on the cover where it is most suitable for that particular issue. This allows more variety in covers and a larger area for the picture or design. In this flag the word "Journal" now appears in Venus extra bold extended type; the words "of the Medical Association" appear in Venus bold extended type; and the word "Georgia" appears in Spartan type. This same flag that appears on the cover

also appears on the contents page and the first page of scientific articles in matched color. The *Journal* has been using new and more variety in colors for these flags. Dr. Ted Leigh has received many compliments for his cover illustrations and the *Journal* is grateful for his interest and enthusiasm.

The type size for the heading of the editorials has been changed to 18 point times Roman. This was designed to give more distinction to this section of the *Journal*.

The type size of the headings for fillers has been changed to 14 point 20th Century times bold. The *Journal* feels that this change was necessary to distinguish fillers from other material in the *Journal*.

Minutes of the various meetings of committees, councils, etc. have been changed to a smaller type size, 7/8 times Roman, to help conserve space. It also separates them from other news about the Association.

Top of the News is a new added attraction to the *Journal*. This appears on a yellow sheet and is reserved for any important happenings that need special attention.

The changes which have been made in the typography and format of the *Journal* were felt to be necessary to maintain its standing in the ranks of Medical Journals.

ACKNOWLEDGEMENT—Mention should certainly be made of the great assistance given by Mr. Krueger and Mr. Kiser (both former managing editors of the *Journal of the Medical Association of Georgia*) in the training of our new managing editors.

REFERENCE COMMITTEE RECOMMENDATION—Commended highly and complimented work of the staff.

HOUSE OF DELEGATES ACTION—Adopted the report of the *Journal of the Medical Association of Georgia* as recommended by the Reference Committee on motion duly made and seconded.

Woman's Auxiliary to the Medical Association of Georgia

MRS. LUTHER H. WOLFF, *President*

It is with pleasure and pride that the Woman's Auxiliary to the Medical Association of Georgia reports briefly on its myriad and varied activities of the year. Since, at present, our fiscal year is only about three fourths complete, reports must at times be estimated.

On the national level you will be pleased to know that your auxiliary compares favorably with other states. Last year Georgia was one of ten states honored for its work in *Today's Health* contest; we were fourth highest in number of *Bulletin* subscriptions and went well over the top of our A.M.E.F. quota. We are proud that one of our members is on the National Board of Directors and another is National Co-Chairman of the Legislation Committee. It also should be noted that Georgia was the first of the auxiliaries to break into the *A.M.A. News*! The second issue of this publication featured a community service project of one of our auxiliaries. These excellent final records of the past year have furnished our standards and goals for the present year.

And now a look at our auxiliary on the state level. Listed below are several of our activities of this year deemed worthy of special attention:

1. Our first overnight Board Meeting and Conference was held June 12-13 at Ida Cason Gardens Motel. This type meeting proved to

be a successful deviation from our usual luncheon and afternoon Board Meetings of the past. The conference was well attended by state officers, chairmen, district managers, and county presidents. At this time the MAG Advisory Board approved our plans for the year. Evaluation sheets revealed that the group wholeheartedly endorsed this type meeting, and felt that the fellowship, information, informal discussion groups and exchange of ideas proved beneficial to all.

2. The Auxiliary to the Medical Association of Georgia (in conjunction with the Georgia League of Nursing and Georgia State Nurses Association has been instrumental in obtaining a charter for the Future Nurses Clubs of Georgia. Looking ahead, these clubs were included in the Articles of Incorporation of the ALLIED MEDICAL CAREER CLUBS OF AMERICA. The first annual convention of Future Nurses Clubs of Georgia will be held in Marietta on April 25, 1959. The convention and charter of these clubs came as a result of an outstanding Recruitment Program and Rally staged in October in Atlanta through the combined efforts of two of our auxiliaries and our two state wide nursing organizations.
3. We are pleased that two of our auxiliaries sponsored the organization of Auxiliaries to the Student American Medical Association at Emory University School of Medicine and the Medical College of Georgia. We will invite representatives of these organizations to be our guests at our Annual Meeting in Augusta.
4. Our State Organization continues to function smoothly and well. An effort to evaluate and coordinate our aims, methods, and activities has been made. Changes have been instigated or recommended when deemed advisable. Combined emphasis on the responsibilities and importance of our district managers seems to be the answer to our organizational and personal communication problems with our ever enlarging roll of auxiliaries. At present we have 42 auxiliaries. The Auxiliary to Wayne County Medical Society was organized this year and the Auxiliary to Colquitt County Medical Society was reactivated.
5. The sale of a notepaper with the Crawford W. Long Memorial Museum motif has been another state-wide project. The sale of this paper served to honor Dr. Long, publicize the Museum, and to provide additional funds for A.M.E.F. and the Museum.
6. We have endeavored to place *Today's Health* in as many high schools as possible in response to your request. Since our budget does not permit this action on the state level, each local auxiliary has been asked to furnish yearly subscriptions to all high schools in their vicinity. The auxiliaries gladly share this responsibility (one auxiliary of 50 members puts *Today's Health* in eight local county high schools and 53 grammar schools).
7. The William R. Dancy Student Loan Fund has been increased by Auxiliary donations averaging

more than \$1 per member this year. Thirty-four loans have been made to medical students through the years from this fund whose net worth is now \$15,339. Our applications for loans continue to exceed our resources.

8. We continue to honor our physicians and call attention of the public to their unselfish service to humanity on Doctor's Day. Our auxiliaries, 100 per cent, planned to note the day in some special way. Auxiliaries continue to contribute original historical and biographical papers depicting some phase of our medical history to our Research in Romance of Medicine files.
9. We have profited by your cooperation, specific encouragement, and special recognition in certain of our fields of endeavor this year, namely, legislation, recruitment, A.M.E.F., and *Today's Health*.

LEGISLATION: Although our auxiliaries were not called on for definite action during the State Legislative session this year, our members are better informed and more vitally interested in medical legislation than ever before. Each County Legislation Chairman received the Washington News Letter and the MAG News Letter. The editorials and articles on Legislation in the *AMA News* have been most helpful. Interest in the forthcoming legislative year was first aroused by Mr. John Kiser's forceful and enlightening talk at our June Board Meeting. He was also in constant demand as guest speaker for our county auxiliary meetings. We appreciate your "loan" of him to promote our legislative interest and information. The trend of our auxiliaries this year has been to include local legislators and their wives at one meeting. Some appeared purely as honored guests, some as guest speakers, others on legislative panels. Definite action on bills on the national level has been taken this year by many members of our auxiliaries through personal letters to our legislators in Washington.

AMEF: The Auxiliary rejoices that the Medical Association of Georgia has taken definite action to promote contributions to our 84 accredited medical schools through the American Medical Education Foundation. We predict that our Auxiliary will have well over \$2,000 to add to Georgia's contribution this year.

PARA-MEDICAL CAREERS RECRUITMENT: Our Recruitment Chairman gladly accepted Dr. Lee Howard's suggestion that she officially represent MAG and the Auxiliary at a number of recruitment workshops and rallies throughout our state this year. At his suggestion she has worked with and under the guidance of the Public Relations Chairman of MAG. Plans have been made and the ground-work provided for an organizational meeting of a State-wide Committee on Health Careers. Our auxiliaries have promoted recruitment work in varied ways. Open meetings for students featuring Para-Medical Career opportunities have been held. The interesting AMA Para-Medical Careers' film, "Helping Hands for Julie" has been extensively shown to interested groups. Health Career Guides and countless pamphlets have been placed in school libraries. Auxiliary sponsored Future Nurses Clubs and Para-Medical Clubs have increased. It is interesting to note that many of our auxiliaries annually give Para-Medical Scholarships varying in value from

\$100 to \$500. Our reports show that over \$2,000 in scholarship funds will be given by our auxiliaries this year.

TODAY'S HEALTH: The sale of this interesting and authentic Health Magazine published by AMA as a public service to promote better health in our nation has been emphasized this year. It now appears that we shall reach our assigned state quota of 1,671 subscriptions.

Other Auxiliary projects will be group for brevity's sake. (1) Many successful safety programs and projects have been sponsored by our auxiliaries this year, emphasizing child safety, home safety, bicycle safety, traffic safety, water safety, safety for the aging, and fire prevention. (2) Through our Civil Defense work, members strive to keep informed of their role and station in case of disaster. Members attend or teach classes in Home Nursing and First Aid, furnish emergency kits for schools and stress home and automobile preparedness programs. Representatives attended the State Civil Defense Meeting and participated in their workshop. (3) An effort has been made to inform Auxiliary members of some of the local and state mental health needs and in general, to assist in Mental Health Education throughout our state. One auxiliary sponsored the formation of a local mental health organization this year. Others either sponsor or work with schools for retarded and/or exceptional children and child guidance centers. Record players, magazines, and other gifts have been furnished our State Mental Hospital and the School for Retarded Children. (4) Public Relations-wise, our state chairman reports that our Auxiliary members have served their communities magnificently this year. Members have taken leadership roles and actively participated in practically all approved health agencies and drives. Speakers' bureaus have been established; health programs presented through many organizations. Members worked with science fairs and other fairs, with rural health programs, and made surveys of health facilities. They have helped with blood banks, the bloodmobile, dental clinics, crippled children's clinics, cancer clinics, pre-school health examinations, and immunizations.

Our *Auxiliary News*, published quarterly, is an efficient means of disseminating pertinent state and national information to our complete membership. Our State Directory published annually, is a valued tool of our organization. Our Auxiliary Report, published and distributed at Convention, gives complete history of the year's work and serves as a guide and as resource material for county auxiliary presidents in planning their new year's work. For your financial support of these publications, we are indeed grateful.

Your Auxiliary President and President-elect appreciate your appropriation of funds to send them to the Fall Conference in Chicago each year. This conference is an essential and valuable experience for these two officers. For the guidance of the MAG Council and House of Delegates, the efficient assistance of the entire personnel of the Executive Office and the time and counsel given by our Advisory Board from MAG, we express our gratitude. We trust that your investments in your Auxiliary pay fruitful dividends.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved and the Auxiliary was commended for its most helpful and beneficial work.

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman's Auxiliary to the Medical Association of Georgia as recommended by the Reference Committee on motion duly made and seconded.

Physician-Lawyer Liaison

W. BRUCE SCHAEFER, M.D., *Chairman*

This Committee met on Tuesday, May 12 in Atlanta and made plans for printing the Interprofessional Code of Cooperation between physicians and attorneys which has already been approved by the House of Delegates of the MAG and also by the Georgia Bar Association. Bids will be obtained from at least two printers and the two associations will share printing costs. Copies of the Code will be sent to every physician and lawyer in the state.

It is recommended by this committee that each district medical society plan at least one program on medicolegal problems each year. It is recommended that three physicians and three attorneys participate in a panel discussion with a moderator. Speakers and sample questions will be furnished by the state committee if desired.

We feel that good physician-lawyer relations should be maintained in Georgia. It is hoped that the Code will serve this purpose. It may need revision at a later time. We hope this Committee can continue to function next year.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved and the Committee was commended in its efforts of obtaining more amicable relations between the two groups.

HOUSE OF DELEGATES ACTION—Adopted the report of the Physician-Lawyer Liaison Committee as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 13 Hospitalization Fund

WARE COUNTY MEDICAL SOCIETY

WHEREAS, Dr. Thomas F. O'Donnell, a member in good standing of the Ware County Medical Society and an employee of the Relief Association of the Atlantic Coast Line Railroad Company, advised the Ware County Medical Society at its regular monthly meeting of May, 1959 that the Hospitalization Fund Regulations of the Relief Department of the Atlantic Coast Line Railroad Company are to be amended effective June 1, 1959, to include another regulation, to be number 82, reading as follows:

"82—All employees of the Atlantic Coast Line Railroad Company and Charleston and Western Carolina Railroad Company, who are not members of the Hospitalization Fund may be received in the hospitals and clinics under control of the department for medical or surgical treatment when so permitted by the Chief Surgeon or the Chief of Staff, and for this privilege reasonable charges will be made, comparable to charges made by outside hospitals or clinics located at the point where the patient is receiving treatment.

"Private rooms may be furnished on authority of the Chief of Staff of the hospital where the patient is receiving treatment, but ward beds will be furnished when private rooms are not available. Where special duty nurses are required, arrangements for and payment thereof will be the re-

sponsibility of the patient or some member of his family."

WHEREAS, it is the interpretation of the Ware County Medical Society that this proposed amendment to the Hospitalization Fund Regulations of the Relief Department of the Atlantic Coast Line Railroad Company indicates that this company proposes to charge fees for the professional services of its salaried physicians and surgeons, and

WHEREAS, it is the interpretation of the Ware County Medical Society that the Relief Department of the Atlantic Coast Line Railroad Company intends to apply these fees to the general support of the Relief Department, and

WHEREAS, it is the interpretation of the Ware County Medical Society that fees so collected will not revert back to the physician or surgeon administering the service, and

WHEREAS, the American Medical Association and the Medical Association of Georgia are strongly and unalterably opposed to the corporate practice of medicine, and

WHEREAS, it is the opinion of the Ware County Medical Society that the aforementioned amendment of the Hospitalization Fund regulations of the Relief Department of the Atlantic Coast Line Railroad Company would result in said companies engaging in the corporate practice of medicine,

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia go on record as being unanimously opposed to the institution of such practice by the Relief Department of the Atlantic Coast Line Railroad Company, and

BE IT FURTHER RESOLVED, that appropriate action be taken by the Medical Association of Georgia to discourage and prevent the Relief Department of the Atlantic Coast Line Railroad Company from carrying out its proposed amendment, and

BE IT FURTHER RESOLVED, that a copy of this resolution be forwarded to the legal counsel of the Medical Association of Georgia for action, and

BE IT FURTHER RESOLVED, that a copy of this resolution be sent to the Executive Secretary of the Medical Association of North Carolina as information.

REFERENCE COMMITTEE RECOMMENDATION—This Resolution was thoroughly discussed by all members present. Dr. Arthur Knight, Secretary of Ware County Medical Society gave a rundown on the problem as did Mr. John Moore, Jr., MAG Legal Counsel.

The Committee believes that this matter can be settled to the satisfaction of all concerned by airing both sides thoroughly.

We would like to go on record as commending the Ware County Medical Society for its prompt action and attempt of solution.

We recommend that the following changes be made in the original Resolution:

Page 2, Paragraph 5, Line 4—The word "would" changed to "could."

Page 3, Paragraph 1—To be amended to read as follows:

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia go on record as being unanimously opposed to the corporate practice of medicine.

Page 3, Paragraph 2—This paragraph was approved as is.

Page 3, Paragraph 3—To be changed as follows:

BE IT FURTHER RESOLVED, that a copy of this Resolution be forwarded to the legal counsel of the Medical Association of Georgia, and

BE IT FURTHER RESOLVED, that the Council be instructed to take appropriate steps to settle this matter.

Page 3, Paragraph 4—This paragraph was approved as read.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 13: Hospitalization Fund, as amended by the Reference Committee on motion duly made and seconded. The entire Resolution as amended by Reference Committee and so adopted by the House reads as follows:

WHEREAS, Dr. Thomas F. O'Donnell, a member in good standing of the Ware County Medical Society and an employee of the Relief Association of the Atlantic Coast Line Railroad Company, advised the Ware County Medical Society at its regular monthly meeting of May, 1959 that the Hospitalization Fund Regulations of the Relief Department of the Atlantic Coast Line Railroad Company are to be amended effective June 1, 1959, to include another regulation, to be number 82, reading as follows:

"82—All employees of the Atlantic Coast Line Railroad Company and Charleston and Western Carolina Railroad Company, who are not members of the Hospitalization Fund may be received in the hospitals and clinics under control of the department for medical or surgical treatment when so permitted by the Chief Surgeon or the Chief of Staff, and for this privilege reasonable charges will be made, comparable to charges made by outside hospitals or clinics located at the point where the patient is receiving treatment.

"Private rooms may be furnished on authority of the Chief of Staff of the hospital where the patient is receiving treatment, but word beds will be furnished when private rooms are not available. Where special duty nurses are required, arrangements for and payment thereof will be the responsibility of the patient or some member of his family."

WHEREAS, it is the interpretation of the Ware County Medical Society that this proposed amendment to the Hospitalization Fund Regulations of the Relief Department of the Atlantic Coast Line Railroad Company indicates that this company proposes to charge fees for the professional services of its salaried physicians and surgeons, and

WHEREAS, it is the interpretation of the Ware County Medical Society that the Relief Department of the Atlantic Coast Line Railroad Company intends to apply these fees to the general support of the Relief Department, and

WHEREAS, it is the interpretation of the Ware County Medical Society that fees so collected will not revert back to the physician or surgeon administering the service, and

WHEREAS, the American Medical Association and the Medical Association of Georgia are strongly and unalterably opposed to the corporate practice of medicine, and

WHEREAS, it is the opinion of the Ware County Medical Society that the aforementioned amendment of the Hospitalization Fund regulations of the Relief Department of the Atlantic Coast Line Railroad Company could result in said companies engaging in the corporate practice of medicine,

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia go on record as being unanimously opposed to the corporate practice of medicine, and

BE IT FURTHER RESOLVED, that appropriate action be taken by the Medical Association of Georgia to discourage and prevent the Relief Department of the Atlantic Coast Line Railroad Company from carrying out its proposed amendment, and

BE IT FURTHER RESOLVED, that a copy of this Resolution be forwarded to the legal counsel of the Medical Association of Georgia, and

BE IT FURTHER RESOLVED, that the Council be instructed to take appropriate steps to settle this matter, and

BE IT FURTHER RESOLVED, that a copy of this resolution be sent to the Executive Secretary of the Medical Association of North Carolina as information.

Resolution No. 16 Stroke Programs

E. C. McMILLAN, M.D. *Bibb*

WHEREAS, cerebrovascular diseases result in a high percentage of deaths and disabilities in Georgia and the nation, and

WHEREAS, approximately 70 per cent of these patients can be rehabilitated to the extent of caring for themselves, and approximately 40 per cent can be returned to gainful work, and

WHEREAS, the Georgia Heart Association in cooperation with the State Department of Health has em-

barked on a program of education and rehabilitation of stroke patients, and

WHEREAS, demonstration centers have been established at Grady Hospital in Atlanta, and in Savannah for training public health nurses, physicians, and patients in stroke rehabilitation, and

WHEREAS, national interest is focused on this Georgia program, an American Heart Association film having recently been made on home demonstration care in Savannah.

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia through its House of Delegates, endorse and approve the stroke program of these agencies and urge the participation of its members in these efforts.

REFERENCE COMMITTEE RECOMMENDATION—Your Committee approves the contents of this program and recommends acceptance.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 16: Stroke Programs as recommended by the Reference Committee on motion duly made and seconded.

It was moved by the Chairman of Reference Committee No. 1, W. P. Rhyne, Albany and duly seconded that the report of Reference Committee No. 1 be accepted as a whole and it was so ordered.

Report of Reference Committee No. 6

JOSEPH B. MERCER, M.D., *Chairman*

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 6 met at 2:30 P.M. on May 18, 1959 in Room 741, Bon Air Hotel, Augusta, Georgia. The Second Session was held in the same location at 9:00 A.M., May 19, 1959. Members present were Joseph B. Mercer, Brunswick, Chairman; David R. Thomas, Augusta; Harry Cheves, Sr., Union Point; T. A. Sappington, Thomaston; Luther Roberts, Columbus; J. D. Martin, Atlanta; David Wells, Dalton; Rafe Banks, Gainesville; E. G. McKay, Thomasville; and S. A. Roddenbery, Columbus, Secretary.

The Report of the Constitution and Bylaws Committee and the Addendum Report of the Secretary were considered at the same time because of conflicting recommendations. The Committee met in open session and then went into Executive Session to hear specific information from various individuals, mostly officers of the Association.

Supplementary Report of the Secretary No. E Addendum Report of the Secretary

CHRIS J. McLOUGHLIN, M.D., *Secretary*

The President and Secretary of your Association are the only two officers elected by the membership at large. The duties of the President are obvious. The duties of the elected Secretary should likewise be obvious. That is, to act in the best interests of the medical profession of Georgia and to see to it that the staff within the headquarters functions properly in accordance with the best interests of the Association. For this reason, it has been customary to elect as Secretary some one who resides in Atlanta. Without

the facility of being near the headquarters, it is impossible for any physician, regardless of his office in the Association, to know what is going on in the headquarters office.

At the present time, according to the Bylaws, the Executive Secretary is responsible to the Executive Committee. This puts the Executive Secretary in the position of having six individuals to whom he can go for approval. This he has done in the past in a way that has led to much confusion.

Regarding the report of the Constitution and Bylaws Committee, I would like to call attention to the fact that only one member of this Committee was present when this report was drawn up. Neither Dr. Eustace Allen nor Dr. William M. Harbin were present, therefore, this could not rightly be called a report of the Constitution and Bylaws Committee. Moreover, these recommendations were not unanimously approved as is reported in the Minutes of the Council meeting. There are several changes that should be made in the Constitution and Bylaws, I agree. These changes are suggested in an addendum to this report after consultation with the Parliamentarian, a member of the Constitution and Bylaws Committee, and others who have studied the situation in detail.

I strongly recommend to the House of Delegates that control of your Association be kept in the hands of physicians and not given over to lay personnel. In other states in which this has happened, it has resulted in great disservice to the Association. For example, in Los Angeles the physician-secretary of the Association is now on a full time basis. An Executive Secretary is an employee, and he should be responsible to the Executive Committee through your elected Secretary. It is recommended, therefore, that the position of elected Secretary be clarified and strengthened in order that the best interests of your Association be properly protected.

The above statements are the result of a considerable amount of thought. They are not made with the idea of gaining prestige. They are based solely on the principle of protecting and strengthening your Association. Some who do not understand the true situation have recommended other changes in the Constitution and Bylaws, but I cannot be indifferent to what I consider the best interests of the Association.

Addendum to the Secretary's Report Recommended Changes in the Constitution and Bylaws

These recommended changes in the Constitution and Bylaws are made after consultation with the Parliamentarian, a member of the Constitution and Bylaws Committee, the Chairman of the Judicial Council of the American Medical Association, and others who have studied this situation in detail.

The Chairman of the Judicial Council of the American Medical Association has stated ". . . the idea of an Executive Secretary is a good one, but it must be controlled. We cannot allow them to make policy nor can we just turn the whole business over to them to operate as they see fit . . . In a medical organization, no one can be a delegate unless he is a member of that organization and none but doctors can be members. So it is not possible for him (an Executive Secretary) to be a

delegate. Furthermore, he is paid "hired help" of the Association subject to its orders."

The Constitution and Bylaws of your Association were drawn up as rules for governing your society, not to delineate the duties of employees. Therefore, it is recommended that all reference to specific lay personnel be deleted from the Constitution and Bylaws. The Constitution and Bylaws will therefore concern itself only with its members all of whom are physicians.

Constitution

Articles V, Section 1

Now Reads: The Editor of the *Journal*, Delegates to the AMA, the Executive Secretary, and chairmen of standing committees shall be ex-officio members of the House of Delegates without the right to vote.

Should Read: *The Editor of the Journal, Delegates to the AMA, and chairmen of standing committees shall be ex-officio members of the House of Delegates without the right to vote.*

Article VI, Section 1

Now Reads: The Treasurer, Editor of the *Journal*, Executive Secretary, and Delegates to the AMA shall be ex-officio members of Council without the right to vote.

Should Read: *The Treasurer, Editor of the Journal, and Delegates to the AMA shall be ex-officio members of Council without the right to vote.*

Chapter III, Section 5

Now Reads: The Secretary of the Association shall be Secretary of the House of Delegates or, in his absence, a Delegate appointed by the Speaker of the House of Delegates shall serve as Secretary of the House of Delegates. The Executive Secretary may serve in this capacity.

Should Read: *The Secretary of the Association shall be the Secretary of the House of Delegates or, in his absence, a Delegate appointed by the Speaker of the House of Delegates shall serve as Secretary of the House of Delegates.*

Chapter IV, Section 2

Now Reads: The Secretary of the Association shall serve as Secretary of Council. The Council may designate the Executive Secretary or Assistant Executive Secretary to serve in this capacity.

Should Read: *The Secretary of the Association shall serve as Secretary of Council or, in his absence a member of Council may be appointed by the Chairman to serve in this capacity.*

Chapter IV, Section 3. Executive Committee

Now Reads: The Executive Committee shall recommend to Council the terms of employment and salaries of all personnel necessary to conduct the affairs of the Association. The Executive Committee shall be empowered to select an Executive Secretary who shall be responsible to the Executive Committee for his action and for the operation of the Headquarters Office, subject to the approval of Council. The Executive Committee shall act as a Board of Trustees directing the Executive Secretary in carrying out the mandates and policies of the Council and the House of Delegates.

Should Read: *The Executive Committee shall recommend to Council the terms of employment and salaries of all personnel necessary to conduct the affairs of the Association.*

Chapter IV, Section 4. Secretary

Now Reads: (A) The Secretary and the Executive Secretary shall attend the general meetings of the Association and the meetings of the House of Delegates. The Secretary shall keep the minutes of their respective proceedings. At the request of the Secretary, the Executive Secretary may serve in this capacity. The Secretary, or upon his request, the Executive Secretary, shall be Secretary of the Council and its Executive Committee. The Secretary shall be an ex-officio member, without the right to vote, of the House of Delegates and all committees of the Association.

Should Read: *(A) The Secretary shall attend the general meetings of the Association and the meetings of the House of Delegates. The Secretary shall keep the minutes of their respective proceedings. The Secretary shall be Secretary of the Council and its Executive Committee. The Secretary shall be an ex-officio member, without the right to vote, of the House of Delegates and all committees of the Association.*

Section 4

Now Reads: (B) The Secretary and/or Executive Secretary under the direction of the Executive Committee of Council, shall be custodian of all Association record books and papers, conduct the official correspondence of the Association, maintain membership records, issue membership cards and provide for the registration of members at annual session.

Should Read: *(B) The Secretary under the direction of the Executive Committee of Council shall be custodian of all Association record books and papers, transmit the official correspondence of the Association, maintain membership records, issue membership cards, and provide for registration of members at annual sessions.*

Chapter X, Section 2

Now Reads: Executive Secretary . . . etc.

Should Read: *Delete all Section 2. (In other words, all reference to lay personnel is deleted from the Constitution and Bylaws of the Medical Association. No one unless he is a qualified member of the Association, and only "a physician holding the degree of Doctor of Medicine, etc." can be a member of the Association. No one but a member of the Association can be a member of the House of Delegates.)*

I strongly object to any changes in Chapter VII, Section 1 whereby there will be any separation of the office of Secretary and Treasurer. In almost every medical society in the country, the offices of Secretary and Treasurer are combined. It promotes better understanding of what is going on within the Association, and this is the only reason for keeping the two positions under the one head. Checks are countersigned by a member of the Executive Committee, the records are further checked by the Finance Committee and independent auditors.

It is earnestly requested that serious consideration be given to these recommendations in the best interests of the Association.

REFERENCE COMMITTEE RECOMMENDATIONS—The Committee disapproves the Addendum Report of the Secretary.

Constitution and Bylaws

THOMAS W. GOODWIN, M.D., *Chairman*

Some six items were referred by the Council and its Executive Committee to the Chairman of the Medical Association of Georgia Constitution and Bylaws Committee which met March 7, 1959 to consider these items. The Constitution and Bylaws Committee after due deliberation, makes the following recommendations with the approval of the Council of the Medical Association of Georgia.

(1) The Committee considered the ambiguity in the wording of Chapter 8, Section 1, Treasurer as it relates to the signing of Association checks when the Treasurer is the same person as the Secretary. An interpretation by MAG general counsel stated that when the Secretary is the same person as the Treasurer, another signature is required other than that of the Secretary-Treasurer. Your committee gave due consideration to this problem along with the problem proposed by the Executive Committee and later approved by Council on the ambiguity in Chapter VI, Section 4, concerning the duties of the Secretary and the Executive Secretary. The committee's proposals on these two items were recommended to the Council of the Medical Association of Georgia and approved by the Council for recommendation to the House of Delegates as follows:

Constitution

Will Read: *Change the name of the Executive Secretary or Assistant Executive Secretary wherever either appears to read Executive Director and Assistant Executive Director respectively.*

Bylaws

Chapter IV, Section 2

Now Reads: . . . The Secretary of the Association shall serve as Secretary of Council. The Council may designate the Executive Secretary or Assistant Executive Secretary to serve in this capacity.

Will Read: . . . *Council may designate the Secretary or Executive Secretary or Assistant Executive Secretary to serve as Secretary of Council.*

Chapter IV, Section 3

Now Reads: The Council shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, the President-Elect, the Immediate Past President, the Secretary, the Chairman of Council, who shall serve as presiding officer, and the Chairman of the Council Committee on Finance.

Will Read: *The Council shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, who shall serve as Chairman of the Executive Committee, the President-Elect, the Immediate Past President, the Secretary, the Chairman of Council, who shall serve as Vice-Chairman of the Committee, and the Chairman of the Council Committee on Finance.* (Addition of the following sentence at the end of Section 3): *Between*

meetings of the Executive Committee, the Chairman of the Executive Committee shall direct the Executive Secretary as to undetermined matters of policy.

Chapter V, Section 1

Now Reads: . . . The Speaker of the House of Delegates and Vice-Speaker of the House of Delegates shall be elected by members of the House of Delegates and shall serve for a term of three years. Other officers shall be elected for terms of one year except the Secretary, Councilors, and Vice-Councilors who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually.

Will Read: (Addition of the following sentence immediately before the last sentence of the section): *No member shall hold the office of Secretary or Speaker more than two consecutive terms.*

Chapter VI, Section 4(A)

Now Reads: The Secretary and the Executive Secretary shall attend the general meetings of the Association and the meetings of the House of Delegates. The Secretary shall keep the minutes of their respective proceedings. At the request of the Secretary, the Executive Secretary may serve in this capacity. The Secretary, or upon his request, the Executive Secretary, shall be the Secretary of the Council and its Executive Committee. . . .

Will Read: *The Secretary and the Executive Secretary shall attend the general meetings of the Association and the meetings of the House of Delegates. The Secretary shall keep the minutes of their respective proceedings. The Executive Committee may designate the Secretary or the Executive Secretary or Assistant Executive Secretary to serve as Secretary of the Executive Committee. . . .*

Chapter VI, Section 4(B)

Now Reads: The Secretary and/or Executive Secretary under the direction of the Executive Committee of Council, shall be custodian of all Association record books and papers, conduct the official correspondence of the Association, maintain membership records, issue membership cards, and provide for the registration of members at annual session. . . .

Will Read: *The Secretary or Executive Secretary, under the direction of the Executive Committee of Council, shall be custodian of all Association record books and papers, maintain membership records, issue membership cards and provide for the registration of members at annual session. . . .*

Chapter VIII, Section 1

Now Reads: . . . The Treasurer shall be a member in good standing for at least three years prior to his appointment and may be the same person as the Secretary. . . .

Will Read: . . . *The Treasurer shall be a member in good standing for at least three years prior to his appointment and may not be the same member who holds the office as Secretary. . . .*

(2) Also referred to your committee was a recommendation from the Council recommending study of the revised and approved additional section to Chapter I, titled Jurisdiction (Chapter I, Membership, Section 10, Jurisdiction). Your committee studied this section and believes that it is clearly stated and needs no change as approved by the House of Delegates, April

30, 1958 and recommends that no action be taken on Chapter I, Membership, Section 10, Jurisdiction.

(3) The Council of the Medical Association of Georgia referred to the Committee certain problems arising in membership status when a physician is a full time commissioned officer in the armed forces and is also engaged in the private practice of medicine in off duty hours. Your committee studied this matter and referred it to the MAG general counsel and with his advisement and the approval of the Medical Association of Georgia proposes the following changes:

Bylaws

Chapter I, Section 4

Now Reads: ACTIVE MEMBERS (second paragraph Item 4) on temporary service in the Reserve Armed Forces. A member excused from the payment of annual dues for service in the Armed Forces shall not be required to pay the annual dues for the period beginning January 1 or July 1 following the date of the member's entrance into service.

Will Read: *On temporary services as full-time commissioned Medical Officers in the Reserve Armed Forces. A member excused from the payment of annual dues for service in the Armed Forces shall not be required to pay annual dues for the period beginning January 1 or July 1 following the date of the member's entrance into service.*

Chapter I, Section 5

Now Reads: SERVICE MEMBERS: Physicians eligible for Service Membership are all full-time commissioned Medical Officers of the Government, in the U. S. Army, Navy, Air Force, United States Public Health Service, Veterans Administration, and Indian Service, and those physicians who have retired from the services by Federal law and who do not engage in active practice. Such members shall not be required to pay the annual dues and shall not be entitled to vote and hold office and shall not have the privilege of Medical Defense, nor shall they receive any publication of the Association except by personal subscription.

Will Read: *SERVICE MEMBERS: Physicians eligible for Service Membership are all full-time commissioned Medical Officers of the Government, in the U. S. Army, Navy, Air Force, United States Public Health Service, Veterans Administration, and Indian Service, and those physicians who have retired from the Services by federal law. Such members shall not be required to pay the annual dues and shall not be entitled to vote and hold office and shall not have the privilege of Medical Defense, nor shall they receive any publication of the Association except by personal subscription.*

Chapter I, Section 6

Now Reads: ASSOCIATE MEMBERS: Associate membership may be granted to physicians who are engaged in State and County medical services and full-time salaried members of approved medical faculties not engaged in the private practice of medicine provided similar action has been taken by the component county society. . . .

Will Read: *ASSOCIATE MEMBERS: Associate membership may be granted to physicians who are engaged in State and County medical services and full-time salaried members of approved medical faculties pro-*

vided similar action has been taken by the component county society. . . .

Chapter I, Section 11 (Addition of a new section to Chapter 1 to be titled Section 11 as follows:) The words "full-time" wherever used in this Chapter shall mean that no time at all is devoted to private practice.

(4) The Council also referred to the Committee on Constitution and Bylaws, Chapter VII, Section 1, titled County Societies with the recommendation that the last sentence of this section be changed to read "*A component society shall consist of 10 or more active members,*" rather than the present wording which states "*A component society shall consist of three or more active members.*" While such a change would in no way be retroactive on societies already chartered by the State Medical Association, your committee felt, after due deliberation, that the wording should be changed to five active members and proposes the following:

Now Reads: *Chapter VII, Section 1, County Societies . . . A component society shall consist of three or more active members.*

Will Read: *Chapter VII, Section 1, County Societies . . . A component society shall consist of five or more active members.*

The Constitution and Bylaws Committee then submits the above recommendations to the House of Delegates and, as Chairman, I respectfully wish to thank the other members of the Constitution and Bylaws Committee whose attendance at our meeting made this report possible.

REFERENCE COMMITTEE RECOMMENDATION—This Committee carefully reviewed all information submitted to it in open session and the answers to specific questions in executive session to arrive at the conclusion that the Constitution and Bylaws Committee report should be amended.

Constitution:

(1) The recommended change in the Constitution was disapproved.

Bylaws:

(1) The recommended change in Chapter IV, Section 2 was disapproved.

(2) Changes recommended in Chapter IV, Section 3 were approved as printed in the handbook:

NOW READS: The Council shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, the President-Elect, the Immediate Past President, Secretary, the Chairman of Council who shall serve as presiding officer, and the Chairman of the Council Committee on Finance. . . .

WILL READ: The Council shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, who shall serve as Chairman of the Executive Committee, the President-Elect, the Immediate Past President, the Secretary, the Chairman of Council who shall serve as Vice-Chairman of the Committee, and the Chairman of the Council Committee on Finance. . . .

The additional sentence at the end of Section 3 was amended to read:

"Between meetings of the Executive Committee, the Chairman of the Executive Committee of Council or his duly appointed representative shall direct the Executive Secretary as to undetermined matters of policy."

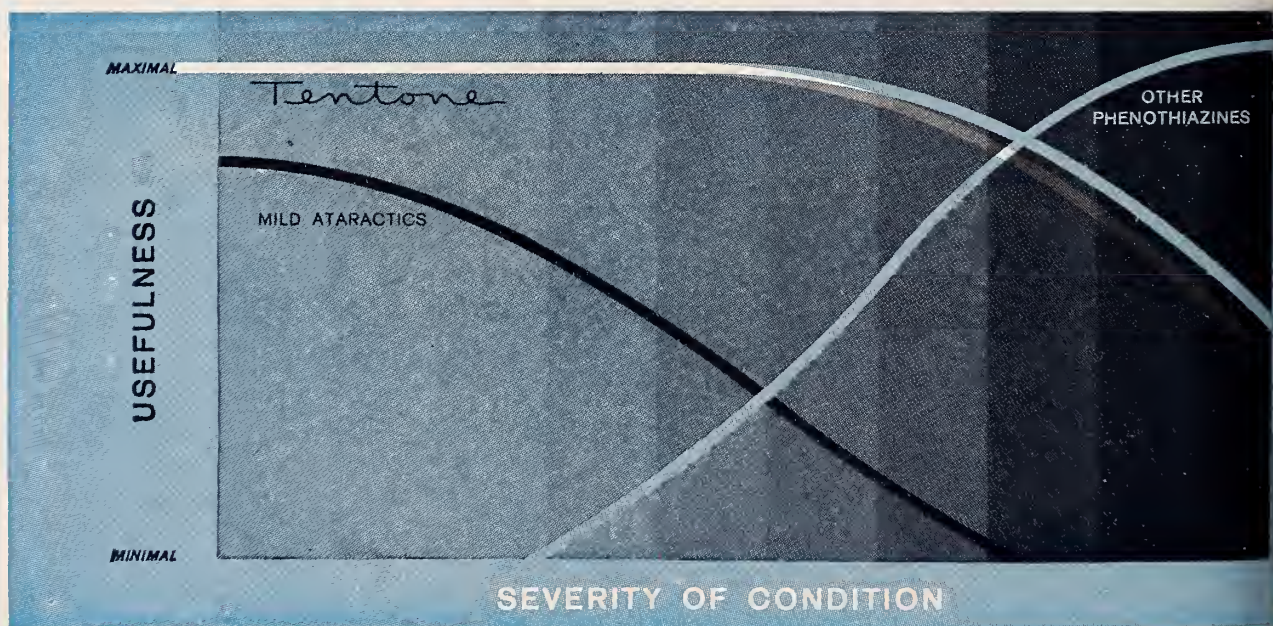
(3) Chapter V, Section 1—The Committee approved the addition of the following sentence immediately before the last sentence of the Section:

No member shall hold the office of Secretary or Speaker more than two consecutive terms.

(4) Chapter VI, Section 4 (A)—Recommended changes were disapproved.

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(5) Chapter VI, Section 4 (B)—Recommended changes were disapproved.

(6) Chapter VIII, Section 1—The Committee approved the changes as printed in the handbook:

NOW READS: . . . The Treasurer shall be a member in good standing for at least three years prior to his appointment and may be the same person as the Secretary. . . .

WILL READ: . . . The Treasurer shall be a member in good standing for at least three years prior to his appointment and may not be the same member who holds the office as Secretary. . . .

(7) Chapter I, Membership, Section 10, Jurisdiction—The Committee approves the recommendation of the Constitution and Bylaws Committee with the following amendment:

At the end of this Section the following sentence should be added: "This shall not necessarily be retroactive."

(8) Chapter I, Section 4—The Committee approved the changes as recommended by the Constitution and Bylaws Committee, and printed in the handbook:

NOW READS: ACTIVE MEMBERS (Second Paragraph, Item 4) On temporary service in the Reserve Armed Forces. A member excused from the payment of annual dues for service in the Armed Forces shall not be required to pay the annual dues for the period beginning January 1 or July 1 following the date of the member's entrance into service.

WILL READ: On temporary service, as full-time commissioned Medical Officers in the Reserve Armed Forces. A member excused from the payment of annual dues for service in the armed forces shall not be required to pay annual dues for the period beginning January 1 or July 1 following the date of the members entrance into service.

(9) Chapter I, Section 5—The Committee approved the Constitution and Bylaws recommendation as printed in the handbook:

NOW READS: SERVICE MEMBERS: Physicians eligible for Service Membership are all full-time commissioned Medical Officers of the Government in the U. S. Army, Navy, Air Force, United States Public Health Service, Veterans Administration, and Indian Service, and those physicians who have retired from the services by federal law and who do not engage in active practice. Such members shall not be required to pay the annual dues and shall not be entitled to vote and hold office and shall not have the privilege of Medical Defense, nor shall they receive any publication of the Association except by personal subscription.

WILL READ: SERVICE MEMBERS: Physicians eligible for Service Membership are all full-time commissioned medical officers of the Government, in the U. S. Army, Navy, Air Force, United States Public Health Service, Veterans Administration, and Indian Service, and those physicians who have retired from the services by federal law. Such members shall not be required to pay the annual dues and shall not be entitled to vote and hold office and shall not have the privilege of Medical Defense, nor shall they receive any publication of the Association except by personal subscription.

(10) Chapter I, Section 6—The Committee approves the recommended changes by the Constitution and Bylaws Committee as printed in the handbook:

NOW READS: ASSOCIATE MEMBERS: Associate membership may be granted to physicians who are engaged in State and County medical services and full-time salaried members at approved facilities not engaged in the private practice of medicine provided similar action has been taken by the component county society. . . .

WILL READ: ASSOCIATE MEMBERS: Associate membership may be granted to physicians who are engaged in State and County medical services and full-time salaried members at approved medical facilities provided similar action has been taken by the component county societies. . . .

(11) The Committee approves the recommended addition of a new Section 11, Chapter I as printed in the handbook:

WILL READ: Chapter I, Section 11—The words "full-time" wherever used in this chapter shall mean that no time at all is devoted to private practice.

(12) Chapter VII, Section 1—The Committee approves the recommended changes by the Constitution and Bylaws Committee as printed in the handbook:

NOW READS: Chapter VII, Section 1, County Societies. . . . A component society shall consist of three or more active members.

WILL READ: Chapter VII, Section 1, County Societies. . . . A component society shall consist of five or more active members.

HOUSE OF DELEGATES ACTION—Speaker Goodwin called for discussion of the recommendations of the Reference Committee. W. Bruce Schaefer, Immediate Past President discussed the Committee's recommendations concerning Chapter IV, Section 3 which was also discussed by Reference Committee Chairman Mercer and Reference Committee member David R. Thomas. Further discussion ensued on Chapter VII, Section 1 relating to the recommendation of the Reference Committee that a component society shall consist of five or more active members. On motion made by Harold P. McDonald, Fulton, and duly seconded, it was moved to raise the number of active members to seven. Speaker Goodwin ruled this substitute motion in order and called for discussion and after discussion the House disapproved this substitute motion.

Speaker Goodwin called for further discussion on the recommendations of the Reference Committee and there being none the House of Delegates adopted the report of the Constitution and Bylaws Committee as amended by the Reference Committee on motion duly made and seconded.

Speaker Goodwin then called for the Reference Committee No. 6 report on the second reading of the 1958 Constitution changes relating to redistricting and councilor reapportionment and the recommended Bylaw changes held in abeyance for this second reading of the MAG Constitution proposed changes.

1958 Proposed Constitution Changes Second Reading

REFERENCE COMMITTEE RECOMMENDATION—After careful evaluation and consideration of all the problems involved, the Committee decided that the recommended changes should not be approved for several reasons. It was the Committee's feelings that, if possible, our districts should conform to the congressional districts. Since it is probable that the state will be redistricted in 1960, it was felt that to make changes now would merely add to the confusion at that time.

The Committee therefore recommends the following changes in the Constitution for first reading only:

Article VI, Council. Section 1. Composition:

NOW READS: Article VI. Council. Section 1. Composition. The Council is composed of the President, the President-elect, the Immediate Past President, two Vice Presidents, Secretary, Speaker of the House of Delegates, and 10 councilors as provided for in the Bylaws. The Treasurer, Editor of the Journal, Executive Secretary, and delegates to the AMA shall be ex-officio members of Council without the right to vote. Vice-Councilors shall be ex-officio members except in the absence of their respective Councilors as provided for in the Bylaws. The Vice-Speaker shall be an ex-officio member except in the absence of the Speaker as provided for in the Bylaws.

SHOULD READ: Article VI. Council 1. Composition. The Council is composed of the President, the President-Elect, the Immediate Past President, two Vice Presidents, Secretary, Speaker of the House of Delegates, and Councilors as provided for in the Bylaws. Delegates to the AMA, the Treasurer, Editor of the Journal, and the Executive Secretary shall be ex-officio members of Council without the right to vote. Vice Councilors shall be ex-officio members except in the absence of their respective Councilors as provided for in the Bylaws. The Vice Speaker shall be an ex-officio member except in the absence of the Speaker as provided for in the Bylaws.

Article IX. Officers. Section 1. Designation.

NOW READS: Article IX. Officers. Section 1. Designation. The officers of the Association shall be a President, President-Elect,

two Vice Presidents, the Immediate Past President, the Secretary, Speaker of the House of Delegates, the Vice Speaker of the House of Delegates, 10 Councilors, and 10 Vice Councilors as provided for in the Bylaws.

SHOULD READ: *Article IX. Officers. Section 1. Designation.* The officers of the Association shall be a President, President-Elect, two Vice Presidents, the Immediate Past President, the Secretary, the Speaker of the House of Delegates, the Vice Speaker of the House of Delegates, the Councilors, and Vice Councilors as provided for in the Bylaws.

The Committee also recommends the following changes in the Bylaws which must be tabled until Constitution changes are made:

Chapter IV. Council. Section 1. Composition.

NOW READS: *Chapter IV. Council. Section 1. Composition.* The Council is composed of the President, President-elect, the Immediate Past President, two Vice Presidents, Secretary, Speaker of the House of Delegates or the Vice Speaker of the House of Delegates, one Councilor or Vice Councilor from each councilor district. Vice Councilors shall be ex-officio members of Council without the right to vote except in the absence of their respective councilors when they shall serve as councilors. The Vice Speaker shall be an ex-officio member of the Council without the right to vote except in the absence of the Speaker when he shall serve in the Speaker's stead. Treasurer, Editor of the *Journal*, Executive Secretary, and delegates to the AMA shall be ex-officio members of Council without the right to vote.

SHOULD READ: *Chapter IV. Council. Section 1. Composition.* The Council is composed of the President, the President-elect, the Immediate Past President, two Vice Presidents, Secretary, Speaker of the House of Delegates or the Vice Speaker of the House of Delegates and one Councilor or Vice Councilor from each councilor district. Component county medical societies having 100 or more active members shall be entitled to elect one Councilor and one Vice Councilor directly representing that society. In these elections, only the members of the component county medical society involved shall be allowed to vote and in those districts which contain the large county medical societies having 100 or more active members, only those members residing in the district outside the large county medical society may vote for the Councilor representing that district. Vice Councilors shall be ex-officio members of Council without the right to vote except in the absence of their respective Councilors when they shall serve as Councilors. The Vice Speaker shall be an ex-officio member of Council without the right to vote except in the absence of the Speaker when he shall serve in the Speaker's stead. Delegates to AMA, the Treasurer, Editor of the *Journal* and the Executive Secretary shall be ex-officio members of Council without the right to vote.

HOUSE OF DELEGATES ACTION—Disapproved the second reading of the 1958 Constitution changes relating to redistricting and councilor apportionment and the Bylaws held in abeyance for this second reading as recommended by the Reference Committee and further approved for first reading only the recommended changes in the Constitution made by the Reference Committee concerning Article VI. Council. Section 1. Composition; Article IX. Officers. Section 1. Designation; and further approved the tabling of the Reference Committee recommended changes in the Bylaws until such Constitutional changes are made as recommended.

Resolution No. 11

Committee Membership

GLYNN COUNTY MEDICAL SOCIETY

WHEREAS, there has been a tendency for membership of the various MAG committees to remain static for prolonged periods of time, and

WHEREAS, this tends to limit the committees to too few members of the Association, and

WHEREAS, this also tends to limit the introduction of new men into the working organization of the Association and thus prevents the introduction of new ideas of the younger members,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the MAG limits the appointment of members to committees so that no member may serve more than one term on the Standing Committees of the Association and suggests that the same rule apply in appointing Special Committees.

REFERENCE COMMITTEE RECOMMENDATION—This Resolution was studied and the following substitution is recommended:

NOW THEREFORE BE IT RESOLVED, that the House of Delegates suggest to Council that the appointment of members to committees be so rotated that all members be given an opportunity to serve the Association. It is also suggested that no man serve more than two consecutive terms on the same Standing or Special Committee except under unusual or extenuating circumstances.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 11: Committee Membership as amended by the Reference Committee on motion duly made and seconded.

Further Recommendations of the Reference Committee No. 6

REFERENCE COMMITTEE RECOMMENDATION—Because of inconvenience to some members in voting, we recommend to the House of Delegates that the voting time be studied by the committee on Constitution and Bylaws and so set as to enable all members attending the Annual Meeting a better opportunity to vote.

We also suggest that copies be kept of all correspondence received by the MAG Headquarters Office and sent out to officers and committee chairmen and a notation made as to disposition.

HOUSE OF DELEGATES ACTION—Adopted the further recommendations of the Reference Committee on motion duly made and seconded.

It was moved by the Chairman of Reference Committee No. 6, Joseph B. Mercer and duly seconded that the report of Reference Committee No. 6 be accepted as a whole and it was so ordered.

Report of Reference Committee No. 3

T. A. PETERSON, M.D., *Chairman*

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 3 met at 8:00 A.M., May 18, 1959 in Room 741, Bon Air Hotel, Augusta, Georgia. Members present were Drs. T. A. Peterson, Savannah, Chairman; Howard C. Derrick, LaFayette, Secretary; Willis P. Jordan, Columbus; Ralph Davis, Rome; Hugh Hailey, Atlanta; P. T. Scoggins, Commerce; Don Schmidt, Cedartown; R. J. Moye, Swainsboro; and John M. McCoy, Atlanta.

Speaker of the House of Delegates

THOMAS W. GOODWIN, M.D., *Speaker*

The Speaker of the House of Delegates would like to call to the attention of all the members of the Association the editorial printed in the April issue of the *Journal of the Medical Association of Georgia* regarding attendance at the meetings of the House of Delegates. The problem of inadequate representation of the smaller county medical societies continues to recur. It

is felt that members of the smaller county societies have points of view and problems which are entirely different from those which confront the larger county medical societies and it is only when a balance is struck in the representation between the large and small societies that legislation which will benefit the entire medical profession in Georgia is sure of being passed.

It is the prerogative of the Speaker of the House of Delegates under the Constitution and Bylaws to fill any vacancy which may occur in the House. These vacancies must be filled by another member of the Society to be represented in case the delegate is not present. Shortly after the close of the first session of the House of Delegates, there will be posted on the bulletin board a list of the county societies who had no delegate present during the first session. The Speaker would appreciate it if any member attending the Convention from any society so listed would contact him in order that these vacancies may be filled prior to the second session of the House. It is at this second session of the House that most of the important work of the House is accomplished. It continues to be the desire of the Speaker to preside over the sessions of the House of Delegates in a fair and impartial manner and to see to it that all sides of controversial questions are thoroughly discussed.

REFERENCE COMMITTEE RECOMMENDATION—Your Committee recommends approval of this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Speaker of the House of Delegates as recommended by the Reference Committee on motion duly made and seconded.

Council of the MAG

GEORGE R. DILLINGER, M.D., *Chairman*

Gentlemen of the House of Delegates:

The Medical Association of Georgia is growing by leaps and bounds. We can only briefly summarize the activities of your Council since the last meeting of the House of Delegates.

At the April 30, 1958 organizational meeting of the Council, George R. Dillinger was elected Chairman of Council for 1958-59 and J. G. McDaniel was elected Vice-Chairman of Council. Edgar Woody, Jr., was officially appointed editor of the *Journal of the Medical Association of Georgia* for 1958-59. J. G. McDaniel was named Chairman of the Finance Committee. Council then recessed and the interim meeting of the Executive Committee was called at which time Chris J. McLoughlin was appointed Treasurer. This was confirmed by Council action. Mr. Milton D. Krueger was appointed Executive Secretary for the year 1958-59.

I wish to pay tribute to the officers and councilors of your Association for their zeal and efficiency as well as the downright "hard work" that they have used in caring for your affairs. The President, Lee Howard, Sr. has worked continuously in your behalf and during the past year I believe that he has spent as much time in Atlanta as he has in his own town of Savannah. Your President-Elect and Immediate Past President have also both been very active. The Association Secretary has been most active and has devoted a tremendous amount of time to the affairs of the Association.

I can only say that your Chairman of Finance, who is also the Vice-Chairman of Council, is one of the

hardest working men in the Medical Association of Georgia. He and his committee have done a magnificent job in their control of the financial affairs of the Association. Edgar Woody, Editor of the *Journal of the Medical Association of Georgia* and his staff must be congratulated for the excellent progress and increased income realized from the *Journal*.

Last, but not least, we must honor our Headquarters Office employees who have done such a magnificent job. Mr. Krueger and Mr. Kiser, Executive Secretary and Associate Executive Secretary respectively, and Mr. John Arndt, Medicare Administrator, have done an excellent job. Every member of the Headquarters Office force is loyal to your Association and most efficient in their work.

FINANCE

The finances of the Association have never been in better condition than they are at the present time. The Council Finance Committee report is as follows:

The Committee members J. G. McDaniel, Virgil Williams, and Charles Andrews have gone over the budget very carefully and present the following budget for 1959 as approved by Council:

	1958		
	Budgeted Income and Disbursements	Actual Income and Disbursements Thru 10/31/58	Proposed Budget for 1959
INCOME			
Income from Dues (2,367 full members, 32 one-half members)	\$ 92,000.00	\$ 95,670.00	\$ 95,000.00
Journal Advertising	32,000.00	31,447.46 (Aug.)	45,000.00
Fees Exhibitors	10,000.00	9,800.00	8,750.00
Interest and AMA	2,500.00	2,730.13	2,600.00
GP	—	840.00	2,520.00
	<hr/> \$136,500.00	<hr/> \$140,487.59	<hr/> \$153,870.00
DISBURSEMENTS			
1. Salaries	\$ 27,600.00	\$ 19,102.60	\$ 27,910.00
Bonus	2,000.00	—	1,542.50
GP	—	840.00	2,520.00
	<hr/> \$ 29,600.00	<hr/> \$ 19,942.60	<hr/> \$ 31,972.50
2. Fixed Allotments			
Pension Payments	\$ 1,200.00	\$ 500.00	\$ 1,200.00
Honorarium Pres.	1,000.00	1,000.00	1,000.00
Atty. Retainer	1,200.00	1,000.00	1,200.00
Special Atty. Fees	3,500.00	3,000.00	1,000.00
Annual Audit	500.00	580.00	500.00
Cont. F.C.M.S.	1,500.00	1,500.00	1,500.00
Insu. & Bonds Pers.	1,000.00	668.82	1,000.00
Woman's Auxiliary	1,300.00	1,300.00	1,500.00
	<hr/> \$ 11,200.00	<hr/> \$ 9,548.82	<hr/> \$ 8,900.00
3. Journal Publication			
Salaries	\$ 4,500.00	\$ 3,887.50	\$ 5,250.00
Bonus	575.00	—	—
Exp. to Journal Conf.	300.00	331.40	—
Eng. and Cuts	1,500.00	883.92	1,500.00
Editorial Asst.	150.00	100.00	200.00
Stationery	400.00	324.55	400.00
Postage	550.00	561.44	650.00
Clipping Service	250.00	239.65	350.00
Add and Supplies	250.00	151.30	250.00
Copyright	50.00	48.00	50.00
Printing	32,000.00	28,589.94 (Oct. 28)	35,000.00
Sales Tax	960.00	857.69	1,050.00
Sundry	75.00	58.41	100.00
	<hr/> \$ 41,560.00	<hr/> \$ 36,033.80	<hr/> \$ 45,375.00
4. Headquarters Expense			
Travel	\$ 4,000.00	\$ 2,487.42	\$ 4,000.00
AMA Travel, Del. Sec.	3,000.00	1,200.00	2,500.00

	1958 Budgeted Income and Disbursements	Actual Income and Disbursements Thru 10/31/58	Proposed Budget for 1959
Meetings	750.00	132.60	750.00
Stat. Ptg. Sup.	1,800.00	1,458.33	1,800.00
Postage	1,500.00	1,107.60	1,800.00
Tel. & Tel.	2,500.00	2,363.15	2,500.00
Depreciation	750.00	—	1,100.00
Office Maintenance	600.00	286.36	500.00
Dues and Sub.	200.00	195.00	200.00
Janitor Sev. and Grat.	400.00	391.00	650.00
Payroll and Unemp. Tax	1,500.00	824.17	1,000.00
Sundry	500.00	304.82	450.00
	\$ 17,500.00	\$ 10,750.45	\$ 17,250.00
5. Annual Session	\$ 12,000.00	\$ 10,180.07	\$ 10,681.00
6. Committee Expense			
1. Rural Health	\$ 800.00	\$ 250.12	\$ 1,005.00
2. Med. Defense	3,500.00	2,337.50	3,500.00
3. Legislation	2,150.00	1,807.53	2,400.00
4. Maternal Welfare	275.00	—	100.00
5. Industrial Health	—	—	300.00
6. Public Service	1,000.00	106.53	1,000.00
7. Ins. and Econ.	400.00	94.08	600.00
8. Awards	1,100.00	1,154.16	100.00
9. AMEF	—	13.24	—
10. Veterans Aff.	250.00	50.32	150.00
11. Hospital Rel.	1,000.00	178.22	500.00
12. History and Vit. St.	200.00	—	300.00
13. Med. Civil Prep.	50.00	—	50.00
14. Blood Banks	720.00	365.57	720.00
15. Mental Health	200.00	54.15	250.00
16. Crawford W. Long	1,000.00	1,999.43	1,500.00
17. Medical Education	—	—	250.00
18. Ministerial Liaison	300.00	—	450.00
19. Tax. Deduct., Inc. C.	50.00	—	—
20. Med. Scho. Course	250.00	109.61	250.00
21. Dist. Sev. Award	100.00	10.00	300.00
22. Physician-Lawyer	500.00	50.00	250.00
23. Medicare Conf.	100.00	140.74	—
24. AMA Del. Meeting	500.00	29.41	500.00
25. Health Column	1,600.00	1,634.24	2,525.00
	\$ 16,045.00	\$ 10,384.85	—
26. Ancillary Pers.	—	—	50.00
27. Headquarters Bldg.	—	—	500.00
28. SAMA	—	—	300.00
29. SMEB	—	—	100.00
30. Geriatrics	—	—	25.00
			\$ 17,975.00
EQUIPMENT	\$ 500.00	\$ 531.28	\$ 750.00
Total Disbursements	\$128,405.00	\$ 97,371.87	\$132,903.50
Contingent Fund	\$ 2,800.00	\$ —	\$ 5,000.00
Medical Educ. and Lic.	—	123.74	—
Stamping Machine	—	964.38	—
Architect	—	250.00	—
Medicare Adv. Conf.	—	105.81	—
Medco Legal Conf.	—	127.87	—
SAMA	—	140.00	—
SMEB	—	79.56	—
		\$ 1,791.36	
Reserve Fund	\$ 5,295.00	—	\$ 15,966.50
Bank Balance	—	\$ 43,988.19	

The Association has had a good year from a financial standpoint. The *Journal of the Medical Association of Georgia* did well and some of the committees did not spend as much money as they originally requested. We must not lose sight of the fact, however, that we are a growing organization and that more and more demands are made on us as the years go by; and these demands cost money.

The time is coming soon, when the quarters we now occupy in the basement of the Academy of Medicine of Fulton County will be too small for us; in fact, we are cramped for space at the present time. The main thing, however, is that Fulton County membership is

increasing rapidly, and they are now eating many times in double shifts prior to their monthly meetings. The space we occupy could be used to enlarge the dining facilities and while they have in no way intimated that they would like possession of our quarters, we must be realistic and know that the time is near at hand when we must find a new location. Elsewhere in the Council Report there is a report of the Building Committee, but your Finance Chairman would like to say that property located in an ideal spot for a building of the MAG is tremendously expensive. We must continue to be as frugal as we can and save enough money either to buy a building or commence a building program within the next two years. See Treasurer's Report for details of present financial condition.

MEDICARE

The next problem that we wish to present is the administration of the Department of Defense Medicare program. Since December 7, 1956, your Association has operated a Medicare Department in conjunction with the Headquarters Office which is now under the able supervision of Mr. Arndt, Medicare Administrator. As you all know, that program has been considerably curtailed by Congress and we believe that we may take pride in the fact that we have been able to operate the Medicare program with one of the lowest administrative per claim costs in the country. A new contract was negotiated in February, 1959 and the work is continuing at approximately 35 to 40 per cent of the volume that it was one year ago. Both the Council and the administrative staff of the Medicare Department wish to express the appreciation for the efforts of the Medicare Review Board which serves in a most effective capacity.

HEADQUARTERS BUILDING

During the year, there has been considerable discussion concerning a Headquarters Building at every meeting of the Executive Committee and of Council. There was one called session of Council to deal with the problem. Council did not approve the land-lease on the Fulton County Medical Society property to expend all of the Association's funds in building on someone else's property. At the present time, further investigation is being made in the development of a new Headquarters Office as the report of this Committee so states:

The Committee is composed of the Executive Committee of Council.

During the past year great interest was aroused in a building which was admirably suited for our purpose, but unfortunately, the present owners were very reluctant to give a firm price and although we made several offers for the building, these were refused. The building would be ideal in every respect having a total area of 6,200 square feet on two floors. There is also parking space for 40 cars, and it has frontage on two streets. It is hoped that the present owners will reconsider the last offer.

The Fulton County Medical Society has been our host for many years now, but with their membership increasing as rapidly as it is, we can readily foresee there will be a demand for the space we now occupy. Therefore, it is essential that we continue to conserve our funds in order to build or purchase a new home for the Association.

CONSTITUTION AND BYLAWS INTERPRETATION

During the past year there has been a great deal of discussion concerning the interpretation of the Bylaws in regard to the activities of the Secretary and of the Treasurer. The problem was first discussed by the Chairman of Council at the time of the election of the Treasurer at the Council organizational meeting. At that time it was decided to ask for legal interpretation from the Association Attorney regarding signing of checks by one individual for the Association. The legal counsel interpreted the Bylaws to mean that it was necessary that two officers of the Association sign the checks for them to be valid.

Other matters concerning the interpretation of the Constitution and Bylaws have continued to come up during the year. After a discussion at the Executive Committee meeting of Council, at the Biltmore Hotel, February 15, 1959, the problem was referred to the Constitution and Bylaws Committee for interpretation and clarification with the aid of the general counsel of the Association.

The Constitution and Bylaws Committee met prior to the March 7-8 Council meeting and went into all of the various problems resulting in misunderstanding and recommended changes in the Constitution and Bylaws (See report of Constitution and Bylaws Committee). This report was approved without a dissenting vote by Council and we hope that these changes will have the effect of clarifying the present Constitution and Bylaws. These recommended changes are referred to the House of Delegates.

GENERAL COUNSEL

At the December 13-14 meeting of the Council, after a general discussion, Council unanimously voted to change the general counsel or attorney for the Association and this was referred to the Executive Committee for action. After consultation and negotiation, the Executive Committee decided to employ Mr. Francis Shackelford as general counsel for the Association starting January 1, 1959.

INSURANCE FORM STANDARDIZATION

I wish to commend Dr. Joseph Mercer, Chairman of the Council Committee on Standardization of Insurance Forms for the excellent job that he and his committee did in this project. After approval by the MAG Insurance Committee and approval by Council, the standardized insurance forms are now an accomplished fact and each member has received a small supply of these forms. Whether the standardized form works or not is up to the membership. If the membership insists on it working, it then will work. If the membership is apathetic, the project will not be successful. Herein is the report of the Council Committee on Standardization of Insurance Forms:

This committee is pleased to report real progress after two years of surveying and planning. Evaluation of action being taken by the other states and working with the Georgia HIC and the Insurance Committee of the MAG has resulted in a standard hospital form.

We are indebted to Mr. Sheffield Owen of the Georgia HIC, who showed interest in our problems after attempts to work with the National HIC were disappointing. The recommendations which this Committee made to Council were:

1. Standard hospital form with group on one side

and individual on the other and an assignment of benefits on the bottom of each.

2. Any additional information requested by a company, or any company—which requires their own forms to be filled out, should be charged accordingly. It was felt that a fair charge would be \$5.00.

3. Certified copies of Death Certificates would be sufficient "Proof of Death" and special forms required by a company should be charged for with the *COMPANY* paying for same.

4. Standard weekly premium insurance forms should be approved (the Insurance Committee of MAG is currently working with Georgia HIC on this form).

In explanation of why we chose this standard form as opposed to what some states are doing in printing much shorter forms, it should be stated:

1. This form was achieved through cooperative effort with insurance industry in a spirit of understanding and good will.
2. The HIC is paying for initial printing and distribution of these forms.
3. The majority of our problems are created by a few companies and working with the insurance industry these companies can be brought into line without animosity and misunderstanding.
4. A basis for cooperative action between the medical profession and insurance industry has been established.

It is felt that a step has been taken in the right direction, but that we should continue to work with the Georgia HIC to achieve further simplification of the standard forms.

INSTITUTION-PHYSICIAN RELATIONS

The problem of institution-physician relations is one that we have with us always. Council wishes to commend the Committee on Institution-Physician Relations headed by F. G. Eldridge for their activity during the year and presents their report to the House for approval as follows:

During the 1957-58 meeting of the House of Delegates of the Medical Association of Georgia held in Macon, Georgia, April 27-30, 1958, approved the following ethical standards for physicians with regards to hospitals in Georgia:

- "(1) Adequate service guaranteed by physicians to satisfy the needs and requirements of the members of the medical staff of the hospital.
- "(2) Charge for services rendered by these physicians must be in the name of the physician or physicians rendering the service.
- "(3) That no employer-employee relationship exist between the hospital and the physician as such relationship is unethical and illegal.
- "(4) Any arrangements made with the hospital by the physician should be of such nature as to require payment for his professional services by Blue Shield rather than Blue Cross and this is strongly recommended.
- "(5) These basic principles of medical ethics so stated should apply to all hospitals admitting 'pay patients' regardless of size and to all physicians practicing in the State of Georgia."

Over a period of years, both physicians and hospitals have allowed *hospital services* and *medical services* to

become so intermingled in certain areas of practice, i.e. anesthesiology, pathology, radiology, and physical medicine, such that confusion results. As each of these specialties depends on lay technicians, a natural result is the incorporation of these duties under hospital services. In some instances physicians have become employees of hospitals as a result. In no instance should any lay organization "sell" the services of a physician per se; in such instances where the hospital does "sell" the physician's service, that hospital is exploiting the physician, and the physician himself violates the code of medical ethics.

The fact that in many instances, the patient having had no contact with the medical specialist, it is understandable that such patient has cause to wonder regarding the special knowledge required of the specialist.

The purpose of the Institution-Physician Relations Committee is to study the situation through a questionnaire to each of the members of the specialty societies in anesthesiology, pathology, radiology and physical medicine, *through the societies themselves*, then institute a gradual change to alter illegal and unethical practices that exist.

It is very important that insurance carriers should be urged to remove *medical services* from hospitalization policies. The medical services must be covered only in medical and surgical policies as only duly licensed physicians provide this type of patient care.

The support of each and every physician in the state is necessary to acquaint hospital administrators, hospital authority members, and insurance companies with the fact that Georgia physicians in all categories intend to practice both ethically and legally throughout all phases of medical practice.

A report of the committee will follow the studies now being made.

COMMITTEE REORGANIZATION

One of the big problems in our association is the multiplicity of committees. At the present time there are about 48 separate committees, many of which are doing work along similar lines. These 48 committees are made up of standing committees, Council committees, and special committees. Our parent organization, the AMA has been undergoing a reorganization and many other state organizations have also considered the problem of reorganization. Our Council Committee on Reorganization of Committees presents the following report:

As Chairman of this Committee I have studied all the available material. The entire committee met at The King and Prince Hotel, March 7, 1959. The entire set-up was discussed and since the American Medical Association has not completed its reorganization, and since the various committees seem to be serving a very definite purpose, we unanimously decided to defer any definite recommendation for change at the present time. We realize the committees are numerous and somewhat cumbersome and that in the near future the set-up can be changed and made more streamlined. It is our opinion that the Committee should be continued; further study made; and recommendations given after the American Medical Association completes its reorganization of committees. We feel the Medical Association of Georgia should arrange its committees to correspond with the national organization.

CULTISTS

Another problem that we have perennially is that of the cultists practicing in Georgia. Again the osteopaths have attempted to attain legislation permitting them to have all rights and privileges of medical practice. The report of the Cultists Committee is as follows:

The Cultist Committee has not been presented with specific problems during the past year.

However, the osteopaths have again attempted to gain full medical practice privileges through legislative changes in the Medical Practice Laws of Georgia.

The Legislative Committee, with the aid of many individual physicians throughout the state and the untiring efforts of the MAG Headquarters Staff, has successfully prevented the alteration of existing laws, or addition to the Medical Practice Act, which would give the osteopathic physicians full medical privileges in Georgia.

Continued efforts on the part of each physician to keep his senators and representatives acquainted with the facts regarding the level of training of osteopaths will aid greatly in forestalling their efforts to gain a status for which their training is inadequate at the present time.

It is the opinion of many physicians that the institution of a basic science law in Georgia would eliminate many of the problems which continually occur and reoccur.

CLARKESVILLE LABORATORY SCHOOL

At the 1958 House of Delegates the Laboratory School at Clarkesville was presented for approval. At the request of the House of Delegates, a Council Committee was appointed to study the operation of this school during its one year MAG approval. This committee was headed by Dr. D. Lloyd Wood of Dalton. While the Clarkesville Laboratory School apparently failed to materialize, Dr. Wood's report for this committee is as follows:

Apparently the Clarkesville Laboratory has not been put into operation. If, and when, it starts the report will be made.

UNAUTHORIZED PRACTICE OF MEDICINE BY ANCILLARY PERSONNEL

During the past year, no problems have been presented to Council concerning the practice of medicine by ancillary personnel. Practice by ancillary personnel is a continuing thing and therefore, I recommend that this problem continue to be studied by a Council committee until the reorganization of committees has been accomplished. Dr. Phillips, who heads this committee reports as follows:

Since the last annual meeting of the Medical Association of Georgia, no matters concerning the ancillary personnel have been brought to the attention of your Committee. It has not been necessary to call a meeting of the committee.

In my opinion, this speaks well for the practicing physicians of our Association. We must always be aware of the fact that a physician is held responsible for the conduct of his employees.

I am indeed glad that I have no adverse report to submit.

1959 MAG ANNUAL SESSION

I certainly wish to commend Henry Tift, Chairman of the MAG Annual Session Committee along with Peter Hydrick, Chairman of Commercial Exhibits,

Ted F. Leigh, Chairman of Scientific Exhibits, Raymond Arp and the many, many physicians and their wives in Augusta on the Annual Session Local Arrangements Committee. Arrangements for this meeting have been reported on by Dr. Tift at each Council meeting and his report is as follows:

Plans for the 1959 Annual Session in Augusta were begun by this Committee shortly after completion of the 1958 Annual Session in Macon. In accordance with the recommendation of the Annual Session Committee of last year, all of the Specialty Program Chairmen for the 1959 Annual Session were Augusta doctors. This has made the planning of the program much easier, and it is recommended that the system of having Program Chairmen who are residents of the host city be continued. I wish to thank W. A. Fuller, President of the Richmond County Medical Society, and all of the members of that Society for their whole-hearted cooperation in planning the 1959 Convention. I also wish to thank Mrs. L. Q. Hair, Convention Chairman for the Richmond County Medical Auxiliary, and the members of her committees for their excellent help.

The work of the chairmen of the Annual Session Committee is made very easy and pleasant by our very efficient Executive Secretary, Mr. Milton Krueger.

The program for the 1959 Annual Session, which is printed as usual in a separate booklet, is in fact the official report of this Committee.

Peter Hydrick, of College Park, has arranged all of the commercial exhibits and his help has been invaluable. Ted F. Leigh, of Emory University, has done his usual fine job as Chairman of Scientific Exhibits.

COUNCILOR APPORTIONMENT AND REDISTRICTING

Thomas Goodwin and his committee on Councilor Apportionment and Redistricting wish to present the following report:

During the year two meetings were held and the final boundaries of the new districts were decided on at the December 1958 meeting of the Council. A report of the Committee was made and slides were shown of the proposed new districts.

There was much discussion about this problem and it was finally decided to refer it to the Special Reference Committee of the House of Delegates which is being appointed to consider changes in the Medical Association of Georgia Constitution and Bylaws. The following alternatives were suggested to the Reference Committee:

(1) Preserve the present representation on Council and the present districts. In other words, do nothing.

(2) Preserve the present districts but allot one Councilor and Vice-Councilor for each society having 100 members or more and an additional Councilor and Vice-Councilor for each additional 500 members in a society. It is understood that members of county societies having more than 100 members will not be eligible for voting on the Councilor and Vice-Councilor from the district at large. This essentially is a compromise measure.

(3) Approve the ammendment to the Constitution and Bylaws as first read at the 1958 House of Delegates meeting. This allows for an increase in the number of districts as well as changing their boundaries. It is to be noted that in 1960, in all probability, the present congressional district set-up in Georgia will again be

changed since it is apparent that Georgia will lose one member of its members in the United States House of Representatives. Whether or not it is advisable for the Medical Association of Georgia to continue to have its districts conform to the congressional districts in the State is questionable.

This recommendation by the Councilor Apportionment and Redistricting Committee has been referred to the House of Delegates by the Constitution and Bylaws Committee for action.

SOCIAL SECURITY

The following motion was approved by Council March 7-8, 1959 by a vote of seven for and four against: "On motion (Goodwin-Alexander) it was voted that Council recommend to the House of Delegates that physicians in Georgia be included under OASI (Social Security) and that the Association AMA Delegates be so advised."

This controversial matter is referred to you for your consideration.

REFERENCE COMMITTEE RECOMMENDATION—This report was discussed in full with Dr. Dillinger, Chairman, being present to aid in the discussion. The Committee reviewed each section of the Report of Council separately as follows:

Finance—This report was recommended for approval and Dr. McDaniel is to be commended for his fine untiring efforts.

Constitution and Bylaws—This report was referred to Reference Committee No. 6.

General Counsel—This report was reviewed and it is recommended that the House of Delegates approve the changes of General Counsel from Mr. John Dunaway to Mr. Francis Shackelford.

Institution-Physician Relations—This report was accepted and approved.

Committee Reorganization—Your Committee endorses this report and proposes that reorganization be deferred until AMA completes their reorganization.

Clarksville Lab School—It was suggested that this school be given temporary approval for one more year and action was referred to Reference Committee No. 5.

Annual Session—This report was approved and Reference Committee No. 3 gave a rising vote of thanks to those on the Committee for the 1959 MAG Annual Session.

Councilor Apportionment and Redistricting—The recommendations of this Committee were accepted and it was recommended that Alternative No. 2 be adopted, that is, "Preserve the present districts but allot one Councilor and Vice-Councilor for each society having 100 members or more and one additional Councilor and Vice-Councilor for each additional 500 members in a society. It is understood that members of county societies having more than 100 members will not be eligible for voting on the Councilor and Vice-Councilor from the district at large."

HOUSE OF DELEGATES ACTION—Adopted the report of the Council of the MAG as recommended by the Reference Committee with the exception of the last paragraph of the Reference Committee Report pertaining to "Councilor Apportionment and Redistricting" which was disapproved on motion duly made and seconded.

Public Health

H. J. BICKERSTAFF, M.D., *Chairman*

The Committee on Public Health is a correlation and general liaison committee without specific regular functions, being composed of ex-officio members who are chairmen or representatives of various special committees on health and related subjects, of which have their own special functions. Therefore, the Committee on Public Health meets only on call rather than regularly.

There were no called meetings of the committee during the current year 1958-59. There were only two

matters referred to the committee, one of which was disposed of by the county medical society from which it originated within ten days of its original reference. This matter was withdrawn by the original referring society and required no action or consideration by the committee, but has been filed for record. The other matter was referred by the Executive Secretary of the Association. In the opinion of the chairman it was of insufficient relevance and weight to justify a meeting of the committee. The Executive Secretary was consulted and agreed that no committee action was indicated, which matter likewise has been filed for record.

Early in 1959 the chairman of the Public Health Committee reported to Council to the following effect. He reiterated these recommendations to the Budget Committee in a letter of October 29, 1958. The chairman now reports his opinion and recommendations concerning this committee to the House of Delegates as follows:

Due to the numerous committees of the Association whose functions encompass various phases of public and individual health and other committees whose responsibilities closely impinge upon public health matters, the Committee on Public Health itself has no well defined functions. Its activities in the two years that I have been chairman have been limited to occasional reference of isolated items that were readily disposed of without a meeting of the committee, plus one called meeting in the entire two years, the business of which might well have been transacted by another committee.

I therefore strongly recommend that a general review of all committees whose functions relate to health be made, looking toward the merging of some committees and the abolishing of some by absorption. As matters now stand the Committee on Public Health could be abolished and the title of one of the other committees slightly changed so as to expand its function to include the few things our present Committee on Public Health does. On the other hand, the Committee on Public Health might absorb one or more of these ancillary committees along with their functions so as to provide sufficient field of action to justify its existence. Change in either one direction or the other would assure all necessary functions and would eliminate a possible source of duplicated expense to the society. It is unnecessary to detail the specific committees referred to since an examination of the list is self-evident.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved.

HOUSE OF DELEGATES ACTION—Adopted the report of the Public Health Committee as recommended by the Reference Committee on motion duly made and seconded.

Radiologic Safety

ROBERT M. TANKESLEY, M.D., *Chairman*

The Special Committee on Radiological Safety was formed to act as liaison to the State of Georgia, Department of Public Health to aid and advise in formulating policies on radiological safety. To date, this Committee has not been called upon and has no function to report for the past year.

REFERENCE COMMITTEE RECOMMENDATION—This report was accepted and approved.

HOUSE OF DELEGATES ACTION—Adopted the report of the Radiologic Safety Committee as recommended by the Reference Committee on motion duly made and seconded.

Headquarters Office

MR. M. D. KRUEGER, *Executive Secretary*
and

MR. JOHN F. KISER, *Associate Executive Secretary*

It is the intent of this report to review the operation and function of the Association Headquarters Office during the past year. The report will also serve to indicate the future trends and scope of activity of the Headquarters staff.

DIRECTION

In accordance with the present Constitution and By-laws, the Executive Secretary, acting as the administrative agent of the Association, of its Council and of all its committees under the direction of the Executive Committee of Council, is the directing manager of the Headquarters Office. The Executive Secretary discharges and is responsible for the administrative functions of the Association not within the duties of the Association officers and committees. Further, the Executive Secretary is responsible to the Executive Committee of Council for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council, and the officers of the Association.

In this capacity, the Executive Secretary directs and manages the Headquarters Office staff. Medical and all policy matters presented to the Association are at all times referred to the Council or its Executive Committee; to the appropriate Committee Chairman or Association officer within whose jurisdiction the matter lies. After policy has been determined, the Executive Secretary then administers the matter. The Executive Secretary prepares a monthly report of activity and status of all administrative matters for the Executive Committee of Council to keep them informed at all times.

The Associate Executive Secretary is designated these duties in the absence of the Executive Secretary. Working jointly with the Executive Secretary, the Associate Executive Secretary also directs certain specific administrative functions such as field travel, public relations, special projects, and other delegated duties. The Medicare program is administered by the Medicare Administrator under the direction of the Executive Committee and the Medicare Review Board within the provision of Public Law 569 as effected by the Department of Defense.

The Executive Secretary, Associate Executive Secretary, and Medicare Administrator, all dealing with the administrative phase of Association work, provide leadership and direction for the Headquarters Office staff.

PERSONNEL

An Executive Assistant was employed at the direction of Council to assist the Executive Secretary and Associate Executive Secretary. The addition of this position alleviates much of the detail load formerly shared by the Executive Secretary and Associate Executive Secretary.

As in the past, other members of the staff include a bookkeeper, handling accounts and membership; *Journal*

managing editor, working with the JMAG editor; and two general secretaries, acting in the varied capacities of stenographer, receptionist, and in mimeographing, filing, addressing, and general office procedures.

It should be noted that the Medicare staff has been proportionately decreased as the October 1, 1958 program restrictions diminished the load of claim forms received daily for processing.

It is believed that the Headquarters Office now has sufficient personnel to adequately staff Association affairs and maintain a high degree of efficiency of output.

FACILITIES

As has been noted in past years, the square footage of space housing the Headquarters Office is inadequate for personnel, equipment, and supplies. On authorization of the 1958 House of Delegates, the Council is presently considering certain sites and types of building for the future MAG Headquarters Office. The Council Headquarters Building Committee is actively concerned with this problem and has the matter under advisement for recommendations to Council.

Office equipment and office furniture is repaired, improved, and replaced at the direction of Executive Committee of Council. More automation to save labor costs is being continually sought and new business procedures are being installed. An example of automation is the preparation and printing of the 1959 MAG Roster which was prepared on IBM punch cards and printed offset from an IBM listing. This processing allowed a saving of approximately \$450 over 1958 and will save approximately \$700.00 in future years.

It is believed that equipment will continue to be a major item of concern in seeking improved business procedures for more efficient operation at less cost.

TYPES AND AMOUNT OF WORK

The Headquarters Office is primarily concerned with a service-type function. The main duties of the office personnel is to staff the meetings of the House of Delegates, the Council, the Executive Committee of Council, Association Committees, and related committees, and carry out the policies and projects of these bodies. Another primary function of staff personnel is to aid and serve the Association's component county medical societies and the individual members. Under the supervision of the editor, the MAG Journal is prepared and published monthly. Even a casual glance at the Association budget gives ample evidence of the great volume of work transacted through the "clearing-house" mechanics of Headquarters Office function. For example, an average monthly mailing runs approximately \$200 which gives an index of activity in handling Association business.

The Headquarters Office also serves many Georgia Specialty Societies. Staff personnel aid and assist the Woman's Auxiliary to the MAG at all times. Of special note is the staffing of the Medicare operation, the administrative duties entailed in working on MAG related committees and many special projects undertaken by the Association each year.

It is believed, that as the Association increases in membership and the scope of its activities, the "work load" of Headquarters Office will increase. Staff members are eager and enthusiastic in anticipating this gradual increase in activity and the office organiza-

tional structure is patterned to absorb new high levels of activity.

SUMMARY

It would be remiss to summarize this report without a word of appreciation to the members of the Executive Committee of Council who are charged with the responsibility of directing the overall activity of Headquarters Office function. The staff also wishes to express its appreciation to the MAG officers, councilors, committeemen, and to the membership for their cooperation—and in words previously said, thanks "to the physician 'who cared,' in that with his cooperation many of the Association ideals and objectives have been achieved."

In summary, it is believed that the Headquarters Office is presently operating in a smooth and efficient manner. There, of course, is room for improvement, but the Association may be assured of the dedication and sincerity of its employees to the end that the MAG will serve the cause of medicine in Georgia.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved.

HOUSE OF DELEGATES ACTION—Adopted the report of the Headquarters Office as recommended by the Reference Committee on motion duly made and seconded.

Mental Health

RIVES CHALMERS, M.D., *Chairman*

The activities of the Mental Health Committee for 1958-59 have consisted largely of individual projects carried out by members of this Committee working in conjunction with other organizations. The Committee has held two meetings during the year at which time its activities have been reviewed and new projects considered. The outstanding event for the Committee this year has been an activity which was carried out by the special study committee of the Medical Association of Georgia appointed by the President at the request of Gov. Vandiver to study reports of irregularities at Milledgeville State Hospital. This activity is not actually considered to be an activity of this Committee, but it does give expression to many of the serious concerns expressed in our Committee over the past several years which have resulted in recommendations for such a study to the Governor and to the Legislature in previous years. The broad recommendations for administrative improvements contained in the study committee report have been discussed and endorsed by this Committee.

During the year, Dr. Trawick Stubbs, Director of the Mental Health Division of the Georgia Department of Public Health, reported the present status of the intensive treatment program being carried on in general hospitals at Talmadge Memorial Hospital, Macon, and Columbus City Hospitals. This program is an activity which directly affects all physicians concerned with providing early care and treatment for patients suffering with mental illness and the early reports indicate that many patients can be treated under this program on a short term basis and returned to their home communities rather than having to be committed to the State Hospital. The Committee considered ways of distributing information regarding this program to all members of the Medical Association of Georgia and plans are underway to develop a continuing program of in-

formation regarding this program to the members of our organization.

Dr. Van de Wetering was assigned as liaison member of this Committee to work with a member of the Academy of General Practice and the Georgia Psychiatric Association in the development of a plan for post-graduate courses to be established for general practitioners in subjects related to psychiatry and mental health. This program is given financial backing by grants from the National Institute for Mental Health and funds are available to sponsoring agencies who will develop such programs for physicians in general practice. A statewide committee has been formed to study this problem further and our committee will play an active part on the development of such courses.

Plans are continuing for the possible development of a Mental Health page in the *Journal of the MAG*.

Plans are underway to provide a speaker to district and county societies throughout the state who will report on activities of the Mental Health Committee and other activities within the field of mental health in the state.

The Chairman attended the annual conference of representatives of state mental health committees convened by the Council on Mental Health of the American Medical Association in Chicago in November, 1958. At this meeting, there were five workshops: (1) The Communicability of Mental and Emotional Illness; (2) Emotional Block versus Brain Damage in the Diagnostic Categories of Mental Retardation or Mental Deficiency in School Children; (3) Education for Psychiatric Medicine; (4) The Joint Commission on Mental Illness and Health—Progress & Problems; and (5) Mental Illness and Health in the Aged. Reports on these workshops are being prepared and will appear in the *Journal of the American Medical Association*. A report can be obtained by writing MAG Headquarters.

REFERENCE COMMITTEE RECOMMENDATION — This report was approved.

HOUSE OF DELEGATES ACTION — Adopted the report of the Mental Health Committee as recommended by the Reference Committee on motion duly made and seconded.

**Supplementary Report of Council No. A:
Milledgeville Committee Report**

GEORGE R. DILLINGER, M.D., *Chairman*

On authority of Council action of Saturday, May 16, 1959, the Council approves and respectfully recommends that the House of Delegates approve the following resolution:

WHEREAS, at the request of the Governor of the State of Georgia a committee from the Medical Association of Georgia appointed by the President and consisting of Drs. W. Bruce Schaefer, Toccoa, Chairman; John A. Bell, Jr., Dublin; Rives Chalmers, Atlanta; Corbett H. Thigpen, Augusta; and R. Hugh Wood, Atlanta, studied Milledgeville State Hospital and prepared a report for the Governor, and

WHEREAS, Governor Vandiver stated that after reading and studying the report, it was one of the finest, most authoritative and all-inclusive public documents he had ever read and that the members of the Committee were due the highest praise for the workman-like job which they had done on that report with-

out any cost whatsoever to the taxpayers of the State of Georgia, and

WHEREAS, it appears that a beginning has been made to improve the care and treatment of the mentally ill in the State of Georgia in part due to the efforts of the Medical Association of Georgia and the Committee appointed to study Milledgeville State Hospital,

NOW THEREFORE BE IT RESOLVED, that the Council and the House of Delegates of the Medical Association of Georgia hereby commends the members of this committee for their outstanding service to the mentally ill of this state,

AND BE IT FURTHER RESOLVED, that the Council and the House of Delegates of the Medical Association of Georgia approves in principle the report of the Committee appointed by the President of the Association at the request of the Governor to study Milledgeville State Hospital.

REFERENCE COMMITTEE RECOMMENDATION — Your Committee unanimously recommends that the House of Delegates unanimously approve this report. (Full report of the MAG Milledgeville Study Committee published in the June, 1959 issue of the *Journal of the Medical Association of Georgia*).

HOUSE OF DELEGATES ACTION — Adopted the report of the MAG Milledgeville Study Committee as recommended by the Reference Committee on motion duly made and seconded.

**Supplementary Report of Council No. C:
MAG Headquarters Office Building**

GEORGE R. DILLINGER, M.D., *Chairman*

On authority of Council action of Saturday, May 16, 1959, the Council approves and respectfully recommends that the House of Delegates approve the following resolution:

WHEREAS, the 1958 MAG House of Delegates authorized Council to "proceed with the purchase or lease of suitable property for a MAG Headquarters Office Building," and

WHEREAS, a sales contract for the purchase of the Gulf Life Insurance Building at 938 Peachtree Street, Atlanta, has been executed by Council subject to the approval of the House of Delegates,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates adopt one of the following resolutions, the first of which Council unanimously recommends:

1. RESOLVED that the House of Delegates approves the sales contract prepared for the purchase of the Gulf Life Insurance Building at 938 Peachtree Street as a headquarters office building for the MAG.

2. RESOLVED that the House of Delegates defers action and hereby calls a special meeting of the House of Delegates in Atlanta, on a date before June 15, 1959 to be set by Council, for the purpose of inspecting the Gulf Life Building before taking action.

3. RESOLVED that the House of Delegates disapproves the sales contract prepared for the purchase of the Gulf Life Building.

REFERENCE COMMITTEE RECOMMENDATION — This report was discussed and it is recommended that the House of Delegates approves the sales contract prepared for the purchase of the Gulf Life Insurance Building at 938 Peachtree Street, N.E., Atlanta as a headquarters office building.

HOUSE OF DELEGATES ACTION—Adopted the Supplementary Report of Council No. C: MAG Headquarters Office Building as recommended by the Reference Committee on motion duly made and seconded. Also on motion duly made and seconded Chris J. McLoughlin, Secretary-Treasurer, was commended for his activity as Chairman of the Association Building Committee.

Supplementary Report of Council No. D: Social Security

GEORGE R. DILLINGER, M.D., *Chairman*

Council recommends that the House of Delegates approves the following action of Council taken Saturday, May 16, 1959:

On motion (Wolff-Hock) it was voted to rescind the previous action of Council regarding Social Security as published in the Handbook on Page 35.

It was further voted to ask each county medical society to vote on social security before the 1960 meeting of the House of Delegates and send their delegates instructed on this issue.

REFERENCE COMMITTEE RECOMMENDATION—It is recommended that the House of Delegates take no action on this report.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Reference Committee in taking no action on this report.

Resolution No. 1 Standardized Insurance Form

WALKER-CATOOSA-DADE MEDICAL SOCIETY

WHEREAS, the Walker-Catoosa-Dade Medical Society in regular session has unanimously protested and disapproved the so called Short Standardized Insurance Form as approved by the Medical Association of Georgia,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia officially disapproves the so-called Short Standardized Insurance Form.

REFERENCE COMMITTEE RECOMMENDATION—Your Committee disapproves this resolution and recommends that the House of Delegates direct Council to reappoint the Council Committee on Standardization of Insurance Forms so that the Committee may continue to study and improve existing forms.

HOUSE OF DELEGATES ACTION—Adopted the recommendations of the Reference Committee in disapproving Resolution No. 1: Standardized Insurance Form and further adopted the recommendation of the Reference Committee concerning the reappointment of the Council Committee on Standardized Insurance Forms so that the Committee may continue to study and approve existing forms on motion duly made and seconded.

Resolution No. 3 Compulsory Social Security

MUSCOGEE COUNTY MEDICAL SOCIETY

WHEREAS, the medical profession is dedicated to the maintenance of the private practice of medicine, and

WHEREAS, voluntary acceptance of one aspect of socialization (viz.) Social Security will inevitably weaken our stand in respect to the socialization of medicine, and

WHEREAS, the average physician cannot and will not retire at any specified age, and therefore will derive

little or no benefit from the National Social Security Program, and

WHEREAS, the Social Security taxes are increasing and will continue to increase to an unpredictable level, and

WHEREAS, if any social security legislation be passed, it will be fully compulsory,

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia continue to oppose the inclusion of its members in the Federal Social Security program, and so instruct its delegates to the American Medical Association.

REFERENCE COMMITTEE RECOMMENDATION—It is recommended that Resolution No. 3 be adopted by the House of Delegates.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 3: Compulsory Social Security as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 12 Committee on Medicare

GLYNN COUNTY MEDICAL SOCIETY

WHEREAS, it appears that the government may encroach more and more on the private practice of medicine, and

WHEREAS, multiple problems have already arisen in administering medicine, and

WHEREAS, constituent medical societies need a responsible agency to head and consider their specific problems which arise, and

WHEREAS, Executive Committee of Council is made up of practicing physicians who are already overloaded with problems of organized medicine and cannot consider specific problems which need detailed discussion (more specifically with medicare) and negotiating with governmental agencies,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates create a Committee on Medicare and Other Governmental Medicine which shall consist of one physician representative from each district of the State to be appointed by the president of the district society for a term of three years. This committee shall meet at least semi-annually, consider problems which arise, consider re-negotiating problems, and other such problems and make recommendations to the Executive Committee for their consideration and final action.

REFERENCE COMMITTEE RECOMMENDATION—This resolution was discussed and your Committee recommends that it be approved by the House of Delegates.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 12: Committee on Medicare as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 15 Charges of Unethical Conduct

BALDWIN COUNTY MEDICAL SOCIETY

RESOLVED, that the House of Delegates go on record as disapproving the manner in which charges of unethical conduct were brought against two practitioners in Milledgeville through the public press rather than in accordance with Part One, Section 18, Principles of Medical Ethics of the AMA.

REFERENCE COMMITTEE RECOMMENDATION — Your Committee recommends to the House of Delegates that no action be taken on Resolution No. 15: Charges of Unethical Conduct. The Committee recommends instead that the House of Delegates of the MAG remind the doctors of Georgia that according to the AMA Code of Ethics "They, and they alone, are responsible for safeguarding the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, upholding the dignity and honor of the profession and accept its self imposed discipline. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession." The House of Delegates should remind local component medical societies of the importance of dealing with such matters at local levels through their own committees on Professional Conduct.

HOUSE OF DELEGATES ACTION — Adopted the recommendations of the Reference Committee in taking no action on Resolution No. 15: Charges of Unethical Conduct and further approved the rest of the recommendation made by the Reference Committee in this connection.

**Resolution No. 19
Support Mental Health**

WALKER-CATOOSA-DADE MEDICAL SOCIETY

WHEREAS, the Medical Association of Georgia through its official committee has recommended the transfer of Milledgeville State Hospital from the State Welfare Department to the State Board of Health, and
WHEREAS, following this recommendation the Governor has seen fit to make this transfer of responsibility, and

WHEREAS, it is by virtue of their public responsibility as well as the commitment of their committee the right, duty, and responsibility of the physicians of Georgia to give their full support, advice, and patient understanding to the State Board of Health in its efforts to improve the care and treatment of mental illness in Georgia,

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia will support individually and collectively the State Board of Health and the State Health Department in this tremendous effort.

REFERENCE COMMITTEE RECOMMENDATION—This resolution was accepted and approved.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 19: Support Mental Health as recommended by the Reference Committee on motion duly made and seconded.

It was moved by Chairman of Reference Committee No. 3, T. A. Peterson, and duly seconded that the report of Reference Committee No. 3 as amended be accepted as a whole and was so ordered.

Report of Reference Committee No. 2

A. J. WATERS, M.D., *Chairman*

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 2 met at 8:00 A.M. on May 18, 1959 in Room 462, Bon Air Hotel, Augusta, Georgia. Members present were: A. J. Waters, Augusta, Chairman; Henry Jennings, Gainesville, Secretary; Robert Gibbs, Decatur; Ruskin King, Savannah; Ralph Roberts, Fitzgerald; Rudolph Bell, Thomasville; and Lamar Peacock, Atlanta.

First Vice-President

GEORGE ALEXANDER, M.D., *Forsyth*

As your First Vice-President, I have attended all sessions of Council since my election and participated in its deliberations. In November 1958 I attended the Fourth District Meeting in Griffin, having gone to the meeting at the request of the Headquarters Office in place of our President, Lee Howard who was unable to attend this meeting. I also attended the winter meeting of the Sixth District Medical Society which was held in Macon in December 1958.

It is my opinion that the Vice-Presidents of the Association might be of more help to the President in the future in attending the meetings of district and county societies, particularly those meetings in the areas of the state in which the Vice-Presidents live. I would like to suggest that where it meets with the President's approval, that the Vice-Presidents might be given a little bit more to do, thereby relieving the President of some of the many things which he is called upon to perform. If the House of Delegates feels that an enabling amendment to the Bylaws is necessary for this, I would like to suggest that such be submitted to be adopted in the usual manner.

It has been a pleasure and a privilege to have served as your First Vice-President during the past year.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the First Vice-President and endorses the recommendation that Vice-Presidents be given more to do.

HOUSE OF DELEGATES ACTION — Adopted the report of the First Vice-President as recommended by the Reference Committee on motion duly made and seconded.

Second Vice-President

CHARLES W. HOCK, M.D., *Augusta*

The most important function and duty of the Second Vice-President is that he provides membership on the Council. He enables representation from a county society that perhaps would not have an active voice in the workings of the Association. The larger county societies in the state should have representation on Council because if individual problems dealing with their society which might not be the same for any other society in the state.

My term of office on Council has given me the opinion that few members of the Medical Association of Georgia probably realize the amount of time and effort devoted by a few individuals toward the smooth running of the organization. The number of hours spent for the members by President Lee Howard and the Executive Committee of Council would be difficult to count. The very capable leadership of Chairman of Council George Dillinger in keeping all of the meetings moving ahead at a speed that allowed a subject to be thoroughly covered and yet not to have time wasted has been quite admirable. The Association is likewise fortunate in having two such outstanding workers as Mr. Milton Krueger and Mr. John Kiser because under their capable direction we do have an extremely well functioning office in Atlanta.

It has been a pleasure to serve as Second Vice-President and to help with the decisions of Council.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Second Vice-President.

HOUSE OF DELEGATES ACTION — Adopted the report of the Second Vice-President as recommended by the Reference Committee on motion duly made and seconded.

Secretary

CHRIS J. McLOUGHLIN, M.D., *Atlanta*

Another year filled with activity has rolled by. This report will mention but not dwell upon some of the outstanding events of your Association during the past 12 months. Each year the volume of work done by committees grows greater; committee activities are more wide spread; the need for more adequate facilities becomes more urgent; more and more physicians are needed to staff the committee; and it behooves each and everyone of us to take an active part in our Association in order that we may, as we have in the past, live up to our motto as "Guardian of Georgia's Health."

Membership figures for the year ending December 31, 1958 are as follows:

Membership		1958
Active (Dues Paying)		2410
Active (Dues Exempt)		347
Associate		18
Honorary		0
Service		39
Total		2814

Membership continues to mount slowly but steadily, and it will not be too many years before we have reached the 3,000 membership class, and at that time, we can request an additional delegate to the American Medical Association.

Committee Activities

Committee activities this year reached an all time high. The committees are well co-ordinated and are producing visible results for their efforts.

Insurance: This is one of our hardest working committees. Our professional liability program is working out well with the St. Paul Mercury Insurance Company with rates considerably less than the average premium. Workman's Compensation and Veteran's Fee Schedules are in the process of revision. Last, but not least, this committee has organized an over-all committee on Care of the Aging which will co-ordinate all facilities for the care of our geriatric population. It is expected that this committee will work closely with the Governor and should be of invaluable assistance to him in keeping Georgia standards high in caring for our aged.

Public Service: This committee has continued its excellent work and a special committee has been set up to continue to provide health columns for publication in all Georgia weekly newspapers. This project has met with great success and is published under the title of "Doc MAG Says." Council, during the past year, felt that the title of "Doc" was not very dignified and that the title should be changed to "Doctor MAG Says." It is recommended that the House of Delegates go along with this feeling of Council.

Hospital Relations: This committee has started on a tremendous task. Its work is just getting under way,

but it will soon become one of the most important committees in our Association.

Talmadge Hospital Liaison: Under the heading of W. Bruce Schaefer, this committee has done an excellent job since the Talmadge Hospital problem was settled last year. It was a great relief to all concerned when this matter was finally settled amicably through a special committee which the American Medical Association sent to Georgia to act as intermediary. Dr. Schaefer's leadership has again been called into service by the Governor who requested that a committee be appointed to investigate the problems that have arisen recently at Milledgeville.

Councilor Apportionment and Redistricting: Thomas W. Goodwin, Chairman of this committee has labored long over this problem. One of the reasons for considering redistricting of our state was because of the rather long distances that some would have to travel in attending district meetings. Personally, I feel that any changes in the present districting according to legislative districts would lead to great confusion. Shortly after the next census is taken in 1960, there will probably be some legislative redistricting, and this would probably solve our problem from this standpoint. Actually, since most districts are scheduled to meet only twice yearly, distance is not much of an inconvenience. As far as Councilor apportionment according to physician population is concerned, this would be worthy of consideration, but at the present time, I would recommend that any changes be withheld for another year or two and that the present system be maintained.

Other Committees: The fact that other committees are not mentioned by name should not be construed as meaning that these committees have been inactive. At the present time, I feel that there are no inactive committees and all have functioned well.

Medicare

Since October when the appropriation of the Federal Government for Medicare was cut rather drastically, the number of claims that now filter through our office has decreased by 60 per cent. I will depend on whether or not the Government sees fit to restore a vast sum of money to the Medicare Program before we will know whether or not the program will reach the great number of claims that it had last year. At that time, we were receiving approximately 2,500 claims per month.

Acting as fiscal agent for the Government in administering this Medicare Program does take up some time of our headquarters staff and does in this way cost the Association some money, nevertheless, I feel that it is in the best interests of all physicians to maintain control of this program, and therefore, feel that we should continue to act as fiscal agent rather than turn it over to an insurance company to administer.

Association Headquarters

We all realize that at the time the facilities so kindly provided by the Fulton County Medical Society in the basement of the Academy of Medicine are inadequate for our needs. Moreover, the membership of the Fulton County Medical Society has enlarged so much in the past few years, they will soon need the space which we now occupy. We are making every effort to find a suitable building and hope that it will not be too long before one is found. By means of strict economy, we

have been able to increase our building fund to an extent where a very substantial payment can be made on a building and notes could be paid off without having to assess the membership for any additional revenues.

Personnel: Mr. Krueger and Mr. Kiser continue to do their work in a very satisfactory way. Mrs. Emily Grinalds has been added to the office staff and some of the work of the Executive Secretary has been unloaded upon her shoulders. This should free Mr. Krueger so that he can devote more time to special problems and to visiting societies and districts throughout the state.

Furniture: Quite a lot of the furniture used in our headquarters has become antiquated and decrepit. Through Lee Howard, Sr., our President some additional furniture was obtained, but this is still inadequate to meet our needs. We have been trying to avoid purchasing any furniture or supplies that were not absolutely needed until we are able to find a new headquarters for our Association.

Legal Counsel: At the December meeting of Council, it was decided to employ the services of Mr. Frank Shackelford of the firm of Alston, Sibley, Miller, Spann, and Shackelford as our legal counsel. We regretted deeply the necessity of having to part with the services of Mr. John A. Dunaway, who for so many years has wisely and ably guided and counseled us.

New Seal: During the past year Council recommended that a new seal for the Association be designed. The clasped hands of the old seal has, in the past generation, come to mean more than fellowship. It is used by many nations of whose principles we do not approve. For this reason, Council felt that it would be advisable to seek something more appropriate. Several designs have been made up, and it is recommended that the House of Delegates approve the changing of the seal and authorize Council to give final approval to the finished design.

Every member of you Association can and should be very proud of it. Your officers and Council have done excellent work during the past year, and Dr. Howard has spent many, many long hours working on your behalf as he traveled from Savannah to Atlanta week after week to conduct the business of the Association. Your Finance Committee has been ever alert to hold expenditures to an absolute minimum. Running an organization as large as this does, however, require funds, and it is recommended that no change be made in the dues assessment at this time. We will need any extra money available to help our building fund. Any reduction in dues would seriously curtail the activities of your committees, but on the other hand, no increase is necessary. The headquarters staff does excellent work and is adequate for our needs of the moment. I would like to urge more active participation in the Association by all members. It is your Association; work with it.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Secretary with the following exceptions and comments. It is recommended that the title of the Weekly Column remain "Doc MAG Soys". Concerning the report of the Councilor reapportioning proposal, this Committee received this for information and notes this matter be referred to Reference Committee No. 6 which has under advisement changes in the Constitution and Bylaws. This Committee has received the report concerning changes in the Seal of the Medical Association of Georgia and wishes to take no action on this, but, the Committee recommends this matter be submitted to the House of Delegates after the proposed Seals are presented for study.

HOUSE OF DELEGATES ACTION — Speaker Goodwin called for discussion on the Reference Committee recommendation on the report of the Secretary. Secretary Chris J. McLoughlin discussed proposed changes in the Seal of the Medical Association of Georgia. Speaker Goodwin recognized John Elliott, Georgia Medical Society who moved that the MAG Seal be left unchanged. This motion was duly seconded and T. A. Peterson, Georgia Medical Society also discussed the motion. After further discussion, Speaker Goodwin called for a vote and by majority vote the action of the House of Delegates approved the Elliott motion that the present MAG Seal be left unchanged.

On motion duly made and seconded the other portions of the Reference Committee recommendation concerning the recommendation that the title of the Weekly Health Column remain "Doc MAG Soys" and the referral of the Councilor Reapportioning proposal to Reference Committee No. 6, etc., were approved.

Treasurer's Report

CHRIS J. McLOUGHLIN, M.D., Atlanta

Attached herewith is a report of the audit as prepared by Ernst and Ernst for the calendar year ending December 31, 1958. It is a pleasure to note that there has been a sufficient amount of money left at the end of the year which can contribute considerably to the funds needed for a new building. It must be noted that this money which has been left over at the end of the calendar year was not accounted for in its entirety by the raise in dues. Without the increase in dues which was voted for 1958, the Association would have ended the fiscal year in the red. Each year your Association faces more obligations and increased activity of its various committees. These committees cannot operate without proper funds, and they form a great part of the strength of your organization. Their activities must be encouraged.

Remember that each year the Finance Committee of Council sets up a budget and apportions money according to the various needs of the Association. This budget must then be approved by Council, and at no time can money be expended without the full approval of Council. All expenditures are further checked by the auditors.

To Miss Thelma Franklin, our most efficient bookkeeper, we all owe a vote of thanks and appreciation for her assistance in watching over the financial affairs of the Association.

ERNST & ERNST
FIRST NATIONAL BANK BUILDING
ATLANTA 3, GA.

ACCOUNTANTS AUDITORS
MANAGEMENT SERVICES

OFFICES IN PRINCIPAL CITIES
ASSOCIATES IN FOREIGN COUNTRIES

Chairman of the Council
The Medical Association of Georgia
Atlanta, Georgia

We have examined the financial statements of The Medical Association of Georgia as of and for the year ended December 31, 1958. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statement of assets and liabilities — by funds and the statements of excess of assets over liabilities and of income and expense present fairly the financial position of The Medical Association of Georgia at December 31, 1958, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Ernst & Ernst

Certified Public Accountant

Atlanta, Georgia
March 3, 1959

STATEMENT OF ASSETS AND LIABILITIES — BY FUNDS
The Medical Association of Georgia
December 31, 1958

	General Fund	Department of the Army— Medicare Fund	Building Fund	Abner W. Calhoun Lectureship Fund	Combined
ASSETS					
Cash:					
Demand deposits and office cash fund . . .	\$31,359.69	\$ 88,819.54	\$ -0-	\$ 142.51	\$120,321.74
Savings deposits	20,000.00	-0-	25,000.00	-0-	45,000.00
	<u>\$51,359.69</u>	<u>\$ 88,819.54</u>	<u>\$ 25,000.00</u>	<u>\$ 142.51</u>	<u>\$165,321.74</u>
Marketable securities:					
United States Government securities—at cost or redemption prices (aggregate quoted redemption prices \$41,652.00) . . .	\$ -0-	\$ -0-	\$ 42,312.00	\$ -0-	\$ 42,312.00
Corporation stocks—at cost (quoted market prices \$5,656.00)	\$ -0-	\$ -0-	\$ -0-	6,101.85	6,101.85
	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$ 42,312.00</u>	<u>\$6,101.85</u>	<u>\$ 48,413.85</u>
Accounts receivable:					
Due from United States Government:					
Service fees paid to physicians and den- tists	\$ -0-	\$104,582.74	\$ -0-	\$ -0-	\$104,582.74
November and December, 1958 provi- sional claim fees	3,071.60	-0-	-0-	-0-	3,071.60
Advertisers of The Journal and sundry other accounts	8,499.67	-0-	-0-	-0-	8,499.67
	<u>\$11,571.27</u>	<u>\$104,582.74</u>	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$116,154.01</u>
Equipment—on the basis of cost:					
Office furniture and equipment	\$14,233.12	\$ -0-	\$ -0-	\$ -0-	\$ 14,233.12
Less allowance for depreciation	5,260.48	-0-	-0-	-0-	5,260.48
	<u>\$ 8,972.64</u>	<u>-0-</u>	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$ 8,972.64</u>
Prepaid expenses of 1959 annual meeting . .	1,831.25	-0-	-0-	-0-	1,831.25
	<u><u>\$73,734.85</u></u>	<u><u>\$193,402.28</u></u>	<u><u>\$ 67,312.00</u></u>	<u><u>\$6,244.36</u></u>	<u><u>\$340,693.49</u></u>
LIABILITIES					
Accounts payable and accrued expenses:					
Trade accounts payable	\$ 518.83	\$ -0-	\$ -0-	\$ -0-	\$ 518.83
Pay roll taxes	248.01	-0-	-0-	-0-	248.01
Provisional claim fees received from United States Government less related expenses of \$21,161.10	3,694.55	-0-	-0-	-0-	3,694.55
	<u>\$ 4,461.39</u>	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$ 4,461.39</u>
Advance from United States Government . .	-0-	193,402.28	-0-	-0-	193,402.28
Due from General Fund to Building Fund .	49,273.46	-0-	49,273.46*	-0-	-0-
	<u><u>\$53,734.85</u></u>	<u><u>\$193,402.28</u></u>	<u><u>\$ 49,273.46*</u></u>	<u><u>\$ -0-</u></u>	<u><u>\$197,863.67</u></u>
EXCESS OF ASSETS OVER LIABILITIES					
Balance at December 31, 1958	20,000.00	-0-	116,585.46	6,244.36	142,829.82
	<u><u>\$73,734.85</u></u>	<u><u>\$193,402.28</u></u>	<u><u>\$ 67,312.00</u></u>	<u><u>\$6,244.36</u></u>	<u><u>\$340,693.49</u></u>

The Constitution and Bylaws of the
Medical Association of Georgia
will be printed in full in the August Issue

STATEMENT OF INCOME AND EXPENSE — BY FUNDS

The Medical Association of Georgia

Year ended December 31, 1958

	General Fund	Building Fund	Abner W. Calhoun Lectureship Fund	Combined
INCOME				
Membership dues:				
Year 1958	\$96,000.00	\$ -0-	\$ -0-	\$96,000.00
Prior years	400.00	-0-	-0-	400.00
Less* allocation to subscriptions to The Journal	12,000.00*	-0-	-0-	12,000.00*
	<u>\$84,400.00</u>	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$84,400.00</u>
Net income from The Journal	4,413.83	-0-	-0-	4,413.83
Interest income:				
United States Government securities—				
Note A	875.00	-0-	-0-	875.00
Increase in redemption value—United States Government securities	-0-	216.00	-0-	216.00
Savings deposits	1,291.50	-0-	-0-	1,291.50
Dividends on corporate stocks	-0-	-0-	263.92	263.92
TOTAL INCOME	<u>\$90,980.33</u>	<u>\$216.00</u>	<u>\$263.92</u>	<u>\$91,460.25</u>
EXPENSES				
Salaries	\$26,290.92	\$ -0-	\$ -0-	\$26,290.92
Less allocation to The Journal	4,020.27	-0-	-0-	4,020.27
	<u>\$22,270.65</u>	<u>\$ -0-</u>	<u>\$ -0-</u>	<u>\$22,270.65</u>
Administrative and other expenses	30,343.04	-0-	-0-	30,343.04
Expenses of 1958 annual meeting, less fees from exhibitors of \$9,625.00	880.06	-0-	-0-	880.06
Lecture expenses	-0-	-0-	250.72	250.72
Trustee's fee	-0-	-0-	13.20	13.20
TOTAL EXPENSES	<u>\$53,493.75</u>	<u>\$ -0-</u>	<u>\$263.92</u>	<u>\$53,757.67</u>
	<u>\$37,486.58</u>	<u>\$216.00</u>	<u>\$ -0-</u>	<u>\$37,702.58</u>
OTHER INCOME				
Received from American Medical Association for services and miscellaneous items	673.63	-0-	-0-	673.63
INCOME IN EXCESS OF EXPENSES	<u>\$38,160.21</u>	<u>\$216.00</u>	<u>\$ -0-</u>	<u>\$38,376.21</u>

Note A—On May 10, 1953, The Council authorized interest received on United States Bonds held in the Building Fund to be recorded in the general fund.

STATEMENT OF EXCESS OF ASSETS OVER LIABILITIES — BY FUNDS

	General Fund	Department of the Army—Medicare Fund	Building Fund	Abner W. Calhoun Lectureship Fund	Combined
Balance at January 1, 1958	\$31,113.25	\$ -0-	\$ 67,096.00	\$6,244.36	\$104,453.61
Income for the year in excess of expenses	38,160.21	-0-	216.00	-0-	38,376.21
	<u>\$69,273.46</u>	<u>\$ -0-</u>	<u>\$ 67,312.00</u>	<u>\$6,244.36</u>	<u>\$142,829.82</u>
Add—deduct* amount transferred from					
General Fund to Building Fund	49,273.46*	-0-	49,273.46	-0-	-0-
Balance at December 31, 1958	<u>\$20,000.00</u>	<u>\$ -0-</u>	<u>\$116,585.46</u>	<u>\$6,244.36</u>	<u>\$142,829.82</u>

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the Treasurer's Report.

HOUSE OF DELEGATES ACTION — Adopted the report of the Treasurer as recommended by the Reference Committee on motion duly made and seconded.

Tenth District Councilor

A. W. SIMPSON, JR., M.D., *Washington*

As Councilor for Tenth District of the Medical Association of Georgia, I wish to report the past year has been a very good one for our District. All component societies have been active, holding regular scientific meetings.

The Tenth District Society has had one of its best years. A summer meeting was held in Thomson, Georgia, on August 19, 1958. There was presented an excellent scientific program with good attendance.

The winter meeting was held in Augusta, Georgia on February 21, 1959 and there was presented what was probably the most outstanding scientific program ever offered at the Tenth District meeting.

I attended all but two meetings of the Council, and at these two was ably represented by David R. Thomas, Vice-Councilor.

It is with a great deal of pleasure that I report the amicable solution of the Talmadge Hospital, Medical College of Georgia.

Counties and Secretaries	December 31, 1958		December 31, 1957	
	MAG	AMA	MAG	AMA
Crawford W. Long				
Ellis Dixon, Athens	45	40	46	39
Franklin-Hart-Elbert				
H. E. Campbell,				
Elberton	24	15	28	15
McDuffie				
H. M. Althisar,				
Thomson	6	6	7	6
Oconee Valley				
George Green, Sparta	13	9	15	10
Richmond				
John B. Bowen,				
Augusta	222	179	214	172
Walton				
Harry B. Nunnally,				
Monroe	9	9	10	8
Warren				
A. W. Davis, Warrenton	2	2	2	2
Wilkes				
M. C. Adair, Washington	11	6	12	8
	332	266	334	260

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Tenth District Councilor and wishes to commend the Councilor for work done this year.

HOUSE OF DELEGATES ACTION—Adopted the report of the Tenth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Tenth District Vice-Councilor

DAVID R. THOMAS, M.D., *Augusta*

I have attended all of the meetings of council during the past year, primarily, because of responsibilities of the Insurance and Economics Committee. Your councilor has most ably attended to the affairs of the Tenth District and has kept me informed as to the matters in the district, but made it unnecessary for me to attend to any of the duties.

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Tenth District Vice-Councilor.

HOUSE OF DELEGATES—Adopted the report of the Tenth District Vice-Councilor as recommended by the Reference Committee on motion duly made and seconded.

Cancer

EVERETT L. BISHOP, *Chairman*

The standing Committee on Cancer is authorized by the Constitution and Bylaws of the Medical Association of Georgia. It is appointed by the President, who also appoints the Chairman from those having the longest service on this Committee. This Committee functions chiefly through its Executive Committee, which is also appointed by the President upon recommendation of the Chairman. The Cancer Committee (or the "Cancer Commission" as it has sometimes been called) is charged with representing the members of the Association in all matters relating to cancer, and *in particular* to advise with the Division of Cancer Control of the Department of Public Health. The Committee is advisory only and has no authority to enforce its recommendations. However, as far as I know there have never been any conflicts.

During the year, there have been no matters to necessitate a meeting of the entire Committee with the inconvenience of time and considerable travel it would entail to many of its members. The Executive Committee has met with Dr. William J. Murphy, Director of the State Cancer Control Program, and with your President, Dr. Howard; representatives of the Executive Committees have also met on occasion with Dr. Murphy and also with Dr. T. F. Sellers, Director of the State Department of Health; and the Chairman has had numerous informal meetings with Dr. Murphy and others during this period.

The State Aid Cancer program under the direction of Dr. Murphy, has continued to progress as it has done through the years. There are 18 State Aid Cancer Clinics approved by the American College of Surgeons, these being operated in connection with approved hospitals which is a requirement for full approval of the clinics. Two other clinics are not approved at this time. The clinics are scattered throughout the state making it fairly easy and convenient for patients to reach them. It must be remembered that only indigent patients are eligible for diagnosis and treatment at the State Aid Clinics and these must be certified to Dr. Murphy by the county welfare agent and the patient's physician.

In 1948 there were 2,800 patients, new and old, seen at the various clinics. Last year, there were 4,300 patients. Recently there has been a slight decrease, due partly to the fact that the Talmadge Hospital has accepted some patients for teaching purposes and these do not go through or become part of the statistics of the Division of Cancer Control. However, it is believed that the number of state aid patients will increase, the rate depending upon economic conditions and also depending upon how careful welfare agents and physicians are in certifying patients as truly eligible for state aid.

The cost of the state aid program has steadily and greatly increased through the years as one would expect with the general rise in all medical expenses and the general cost of living. In 1948, the Division of Cancer Control spent \$188,000 for an overall of 2,890 patients.

Last year the cost was \$425,000 for 4,300 patients, 2,800 of which were new patients, and of these 900 were found not to have cancer. Seventy per cent of the cost goes for hospitalization with the state paying the hospitals at a rate of 75 per cent of the actual cost. No physician receives anything for professional services and to these everyone is greatly indebted.

No extra funds in sight at the present time and everything possible should be done to keep the cost of the program as low as possible without sacrificing efficiency. It would be difficult to operate the program as efficiently or as completely as it has been if available funds were reduced. Therefore, it is imperative that the patients be carefully screened by the welfare agents in their certification, and that ineligible patients and/or those without cancer not be referred by the physicians through the welfare agents. Some patients have been referred without definite or even any suspicion of cancer, or in other words, they have been referred as diagnostic problems only. In spite of the slight decrease of patients, there has been an increase in the number of patients, particularly negro patients, who have non-malignant or even non-neoplastic conditions. Certainly these things need consideration and correction, as does the unnecessary delay or the overstay of the patient in the hospital. Cancer is an expensive disease and where a little can be saved here and there, it will mean that other patients may not be deprived of deserving and necessary treatment. I urge you strongly to consider well each individual patient whom you may wish to refer for state aid. They must be deserving of state aid services and must be believed to have some form of cancer which offers a reasonable hope of cure. Incurable cases are not acceptable for state aid.

The close liaison between the Division of Cancer Control and the Georgia Division of the American Cancer Society has worked extremely well and the indigent cancer patient in Georgia has benefited greatly. The Cancer Society has relieved the state aid program of the cost of some essential items, particularly the cost of transportation of patients to and from clinics, although it is very probable that this is overdone for undoubtedly many patients would be able to get to the clinics without cost to either the Cancer Society or the State Aid Division. Pain relieving drugs are expensive and this cost has been for the present and in the past, assumed by the Cancer Society. Many, in fact most, of those concerned with the cancer control program, are very active with the Georgia Division of the American Cancer Society and I would refer you to the resolution passed last year in regard to the close cooperation of the Cancer Committee and the Medical Association of Georgia in general with the American Cancer Society, and all members of the Association are urged to participate to the fullest in the activities of the Cancer Society.

About three-fourths of the State Aid Clinics are operating Cancer Registries and undoubtedly others will follow, for these registries are sources of accurate records, statistics, and other information. As the clinics are in approved hospitals, these registries also include even the private cancer patients and many hospitals without clinics I am sure, eventually will have organized registries with possibly a central state registry as outlined by the American College of Surgeons. However, our statistics throughout the State are at present, I believe,

incomplete, inadequate, and perhaps in some respects inaccurate, for some statistics are in part based upon comparison or percentage, and no one can determine the exact number of cancer deaths, or cancer cases. Some states make cancer a reportable disease and such might be considered in Georgia. I am informed that it was tried some years ago for a short time. An attempt was made a few years ago to report all cases of cancer to the State Department of Health, and some are still being reported to the Vital Statistics Division. However, I believe it would be of great advantage to report every case of *proven* cancer to the state as some other diseases are. In the past the Georgia Association of Pathologists agreed to cooperate and to report all cases of proven cancer based upon the pathological diagnosis, which after all would be the basis for classification, for the clinical diagnosis might or might not be correct. It is believed that this would be given consideration by the new Cancer Committee of the incoming administration.

An important part of any program is education and the right kind of publicity, both public and professional. This is particularly true of the cancer program. Upon recommendation of the Cancer Committee, the Cancer Control Service has for a number of years subscribed to and mailed "The Cancer Bulletin" to every physician in the state, and the Georgia Division of the American Cancer Society sends every physician requesting it (about 2,000) their periodic "CA" bulletin of the recent advances in research, diagnosis, and treatment of cancer. The Professional Education Committee and the Public Education Committee of the Georgia Division are both very active. The Professional Education Committee and your Cancer Committee cooperate in supplying speakers for medical meetings on the county and district levels for the medical supervision of the showing of movie films on cancer, these films being for lay groups as part of the Public Education program. The *Journal* of the Association carries a "Cancer Page" each month. These short and pertinent articles are written and submitted by the various members of the Professional Education Committee or by others selected by them. Both Committees cooperate in supplying speakers for lay groups, civic organizations, PTA meetings, etc., and there are many. The volunteers deserve a great deal of thanks for their efforts in the cancer program as do some of the specialized medical groups and societies for their special meetings and their seminars with invited speakers of national and international reputation. The "Progress Report by the Governor to the General Assembly" last Fall included a section concerning the State Aid Cancer program. As regards information given to the press and to lay publications, such should be as well supervised as possible for timeliness, appropriateness, and above all, accuracy.

In conclusion, close cooperation is essential between all concerned, and everyone, layman and physician alike, should be concerned with the cancer problem in all its phases. It is not a job for any single individual, and single committee, group, or organization, but for all working together in the fight against CANCER, THE GREAT KILLER. Advances are being made steadily, but we are still a long way from knowing many of the answers to the cancer problem. It will take more time, effort, and money but results so far show that these are very worthwhile in the saving of lives of

those who would otherwise be lost and in preventing untold suffering and sorrow. I have been engaged in cancer work for a long time, over a third of a century, and during that time I have seen much of the progress that has been made, some undreamed of years ago, but perfectly evident today and with the future bright for even greater accomplishments.

Having been a member of this Cancer Committee for over 25 years, Co-chairman for a number of years with the late Dr. J. L. Campbell, who did so much toward cancer control in this state, and twice chairman of the Committee, it has been a pleasure and a privilege of serving as Chairman again during the past year.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Cancer Committee.

HOUSE OF DELEGATES — Adopted the report of the Cancer Committee as recommended by the Reference Committee on motion duly made and seconded.

Crawford W. Long Memorial Committee

LESTER RUMBLE, JR., M.D., *Chairman*

The Crawford W. Long Memorial Museum in Jefferson, Georgia has had a very interesting year. This project has been visited by representatives of over 20 foreign countries and by everyone in the now 49 states of the union. Without exception these visitors have been impressed by the project, though now still small in size.

The pressing problem of the Crawford W. Long Memorial Committee has been the upkeep and financing of the museum. Roughly, the expenses of the museum come to \$300.00 per month. For this outlay we provide a full-time care-taker and in the same person a full-time hostess and guide who does an excellent job of explaining what is there and what the museum is all about. In addition to this, with the help of part-time people, she does the cleaning and upkeep work on the museum. This is mentioned to show that the museum is being maintained at a minimal expense for the service rendered. Our financial problems were partially solved by the additional allocation of funds at the annual meeting last year. In spite of this allocation, we found it necessary to apply to the Georgia Historical Commission for funds to continue to operate in November and December. When it became apparent that the expense was going to be this great the Committee realized that the Medical Association of Georgia could not afford to continue complete upkeep of this museum.

As a result of this discovery, a group of individuals in the City of Jefferson, Georgia, formed a corporation, non-profit in nature, for the purpose of maintaining and enlarging the Crawford W. Long Memorial. This corporation has been certified as being a tax free body by both state and national government and is incorporated in the State of Georgia to receive funds for this purpose. Naturally any donations will be greatly appreciated.

It was felt, however, that donations could not be depended upon to continue the maintenance of this project and certainly would not be sufficient to carry out the enlargement which we still hope for in the near future. Thus, we have begun to place a small charge on the brochures which are available to each individual that visits the institution, these brochures giving a com-

plete description of the material contained within the museum. In addition, there are on sale souvenirs and post cards which were requested by many visitors.

Our thanks also goes to the Ladies' Auxiliary of the M.A.G. who financed the printing and sale of note paper bearing the etching of the outside of the museum, since a portion of the proceeds from this sale is being donated to the museum this year.

At the present writing some 15 foundations in the State of Georgia have been approached about the possibility of enlarging this museum to a full square block and making out of it a Memorial Park. This plan would promise Georgia the first museum devoted to the science of pain and its eradication and would be a most worthwhile project, not for the state, but would become a national attraction. However, none of the foundations has seen fit for one reason or another to allocate the monies necessary to purchase the property and reconstruct the present buildings in order that this purpose might be accomplished. Thus, I use this medium to ask that anyone who has access to any foundation that might be interested in such a project, please contact me or some member of the committee at your earliest opportunity. Let me encourage each person who reads this report to take the opportunity in passing through Jefferson, to allow a couple of hours to view the museum and be apprised at what at least a portion of the M.A.G. funds have gone to support.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Crawford W. Long Memorial Committee and wishes to commend Dr. Lester Rumble and his Committee for work done and to officially express appreciation to the Woman's Auxiliary to the Medical Association of Georgia for efforts expended in raising funds for this Committee.

HOUSE OF DELEGATES ACTION — Adopted the report of the Crawford W. Long Memorial Committee as recommended by the Reference Committee on motion duly made and seconded.

Public Service

JOHN P. HEARD M.D., *Chairman*

During the past year, the Public Service Committee held a President's and Secretary's Conference in Atlanta on February 15, 1959, to indoctrinate the new County Society Officers. A large portion of the officers were present and this meeting was considered a success.

Work has begun on publication of a Medical Society Officer's handbook to instruct the officers in their duties and responsibilities to the society.

Work has been done with the Woman's Auxiliary making plans for para-medical recruitment.

Work is being done on a film library and the recent AMA film on food fadism has been secured and given to the Georgia Department of Nutrition in order that it may be shown throughout the State.

A public relations supplement to the Augusta newspaper is being prepared for publication on May 17, 1959, the date the annual session begins.

The Chairman of the Committee was sent to the AMA Public Relations Conference in Chicago in August, 1958.

Plans for the year include continuation of these present projects with a repeat of our President's Conference. We also hope to begin a program of highway

safety and to begin a program of better press relations for the Association.

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Public Service Committee and commends the Chairman and his Committee for work being done in the field of public service.

HOUSE OF DELEGATES ACTION—Adopted the report of the Public Service Committee as recommended by the Reference Committee on motion duly made and seconded.

Medical Civil Preparedness

EDGAR M. DUNSTAN, M.D., *Chairman*

The activities of this committee for the year 1958-59 may be summarized as follows:

1. Continued in an advisory capacity to the State Civil Defense Health Services Division on Medical Civil Defense matters.

2. Participated in the Coordination Activities of the Implementation Committee for Region Three (South-eastern States) of the Federal Civil Defense Administration.

3. Participated in the third year of instruction in the Course in Catastrophic Injuries and Diseases instituted by the Emory University School of Dentistry as a regular course for senior dental students.

4. The following articles were published in medical publications by members of the committee:

a. "Mass Emergency Care of Head Injury" by Dr. Chas. E. Dowman, in JAMA, Vol. 166, page 937 (Feb. 22, 1958).

b. "The Civil Defense Emergency Hospital for Disasters—the Basic Training Unit and Hospital Bed Reservoir" by Dr. Edgar M. Dunstan, in *Hospital Management*, Vol. 87, No. 1, page 38 (January, 1959).

The committee recommends that:

1. The composition of the Medical Civilian Preparedness Committee continue as at present, namely, one member from each of the six key civil defense areas of the State together with any other members-at-large that the President may wish to appoint.

2. The advisory and coordinating functions of the committee continue as in the past.

3. Intensified efforts continue to be made to assist the Georgia Civil Defense Health Services Division to secure more Civil Defense Emergency Hospitals for storage near all major target areas in Georgia and urge the Division to sponsor joint practice run exercises, with these units as nuclei, to insure that all sections of the State are adequately prepared to cope with natural and enemy-caused disasters whenever these may occur.

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Medical Civil Preparedness Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Medical Civil Preparedness Committee as recommended by the Reference Committee on motion duly made and seconded.

A.M.E.F.

GEORGE T. NICHOLSON, M.D., *Chairman*

The American Medical Education Foundation Committee for the Medical Association of Georgia was some what more active during the past year than dur-

ing the previous one. However, due to the ever increasing threat of socialized medicine and government control of medicine, it becomes more and more apparent as the years go by that this committee is not only an important committee of the association, but perhaps one of its vital committees. We appreciate the response of the doctors of Georgia to have given voluntarily to the AMEF, but in comparison to the amounts received by the two medical schools the donations have been pitifully small.

I am happy to report that during 1958 our contributions to the American Medical Education Foundation increased from \$3,586.12 to a grand total of \$4,494.60. There was also a growth in the number of contributions from 149 in 1957 to 230 in 1958 which is a very good increase. But, in view of the fact that the two medical schools received over \$72,000.00 from the National Fund during the past year, it can be seen quite obviously, that the doctors of Georgia are not doing their part in contributing to the National Fund.

I would like to point out at this time that donations can be made through the American Medical Education Foundation and that these donations can be earmarked for a specified medical school. It is urged, however, that the doctors of Georgia contribute at least \$5 per active dues-paying doctor during the current year, which would give us approximately a \$10,000 contribution to the National Fund.

At this time, we of the committee would like to extend our heartfelt thanks to the Woman's Auxiliary of the Medical Association of Georgia for their very active support of the American Medical Education Foundation. If it were not for these good women, taking a very active interest in the committee and in the National Foundations, our contribution would amount to approximately half of what they did last year.

During the past year the Headquarters Office of the Medical Association of Georgia assisted us in mailing letters to each county medical society secretary urging that when dues were paid, a voluntary contribution of \$5 per active dues-paying doctor be collected and forwarded either to the state office or to national headquarters. Several societies, we are happy to say, have contributed 100 per cent. Other societies have been very apathetic and only a very few individuals from those societies have contributed and this not as a part of the activities of the medical society.

We would like to again urge that action be taken of an appropriate nature to insure the collection of \$5 per active dues-paying member whether this be done on a voluntary plan or that the House of Delegates of the Medical Association of Georgia take such action as necessary to collect the above on a compulsory method. This was recommended last year, but action was denied and from this report you can see that the voluntary contribution plan has not worked as well as could be hoped.

We assure the Association of our continued interest in this committee and wish to express to the Headquarters Staff and the officers of the Medical Association for their efforts in our behalf.

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the AMEF Committee with the following comments. Special note was given to the fact that 1958 Georgia doctors contributed \$4,494.60 to the AMEF and

that the two medical schools received \$72,000 from the above mentioned fund. It is recommended that county medical societies establish an assessment of \$5.00 per member per annum to be forwarded to the AMEF and that efforts be made to collect this money by the component medical societies through whatever means are necessary.

HOUSE OF DELEGATES ACTION—Adopted the report of the A.M.E.F. Committee as recommended by the Reference Committee on motion duly made and seconded.

Weekly Health Column

HOWARD C. DERRICK, M.D., *Chairman*

The Weekly Health Column Committee was appointed early in 1958 and is now completing its first year of activity. The Committee has met often during the past year and has prepared more than 50 articles for publication. These articles have been of popular interest and have concerned various diseases, conditions, and situations related to medical and health care.

Of the 197 weekly newspapers in Georgia, 148 have published "Doc MAG Says" one or more times. The Health Column is mailed only to weekly newspapers. In total numbers of insertions, it has been published 1,843 times from April 16, 1958 to March 18, 1959. "Doc MAG Says" has been published in 111 counties in Georgia out of the 148 which have weekly newspapers.

The committee is greatly indebted to the professional writer who assists in editing the columns. The writer is paid a modest amount for these services.

I wish to thank the members of Council and the Finance Committee for their interest and support in this important project. I also wish to commend all of the members of the Committee who work so diligently during the year. The members of the committee are as follows: H. C. Derrick, Lafayette, Chairman; Jule C. Neal, Jr., Macon; August S. Yochem, Jr., Atlanta; Lamar F. Glass, Atlanta; C. J. Wyatt, Rome; E. P. Inglis, Marietta; and T. J. Vansant, Marietta. Thomas P. McPherson, Atlanta resigned during the year from the Committee.

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Weekly Health Column Committee and congratulates the Committee on the work they are doing in this field of public service.

HOUSE OF DELEGATES ACTION—Adopted the report of the Weekly Health Column Committee as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 5 Auto Safety

SPALDING COUNTY MEDICAL SOCIETY

WHEREAS, there is a continued increase of automobile accident injuries and deaths, and

WHEREAS, there has been a public lethargy regarding automobile accidents,

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia go on record as in favor of and the proponents of the following pieces of Legislation regarding the Automotive Code of the State of Georgia:

1. Stricter automotive licensure requirements, including a physical examination with minimum physical requirements as noted in the Truck Driver's Code with

a few exceptions for physical impairments that do not add to the risk of the driver being on the highway.

2. Driver's licenses to be renewed every three years with a physical examination required as in accordance with Number 1, in order to prevent drivers who have become physically disabled during the licensing period from continuing to get driver's licenses without consideration of physical changes. This can be staggered in order to eliminate a heavy burden on the licensing bureau. No permanent type license will be issued and any veteran's license must be renewed as any other type of driving license.

3. All automobile licenses should be laminated in plastic with the photograph of the driver and a thumb print on the license in order to give positive identification of the driver and prevent false use of the driver's license.

4. A driver's license or a chauffeur's license be required before an automobile can be purchased and that the dealers must, by law, ascertain that the purchaser of the automobile has a driver's license or chauffeur's license, before he sells the purchaser an automobile.

5. Regular automobile inspection requirements regarding safety factors made by a special unit of the highway patrol and that a sticker showing that the automobile is safe be required on every vehicle in the State of Georgia.

6. Under the Automotive Code, there should be a law stating that drivers who drive under the influence of alcohol or who are accident prone, that is, who are involved in repeated accidents through their own negligence, will have their licenses suspended automatically with a confined period of suspension.

7. Tightening of the Automobile State Code with punishment in proportion to the severity of the crime committed in an effort to eliminate the potential hazardous drivers on the highways. Judges should be instructed to follow this changed Code and not temper justice with mercy where mercy is not indicated.

8. That the American Automobile Association and the State Highway Patrol be supported in an effort to get the State Education Department to maintain a full term required course on driving in every high school in the State of Georgia.

9. Require all bus drivers for school buses to pass the physical requirements as under the Truck Drivers Code of the State of Georgia and a careful screen of all bus drivers in order to assure the parents of the children that they will be safely transported to and from school, and that it shall be a violation of the State Law to overcrowd any school bus beyond its capacity.

10. That anyone who operates an automobile, bus, or truck in the State of Georgia, shall be required to have liability insurance and/or assets to cover liability, before they can purchase an automobile tag.

BE IT FURTHER RESOLVED, that in as much as the doctors are constantly aware of the number of people who are maimed for life and have been made useless citizens because of avoidable accidents, that the MAG and the AMA through their public service committees go on an active campaign to inform the public regarding the need for more rigid driving codes throughout the United States, this to be done without conflict with the program already sponsored by the National Safety Council.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts in principal and wholeheartedly endorses the subject of Auto Safety. Due to the seriousness of the situation and the many facets involved it is recommended that this resolution be referred to the Public Service Committee for immediate action and that Council be empowered to take any necessary action.

HOUSE OF DELEGATES ACTION — Adopted Resolution No. 5: Auto Safety as recommended by the Reference Committee on motion duly made and seconded.

**Resolution No. 18
Automobile Accidents**

HALL COUNTY MEDICAL SOCIETY

WHEREAS, the Hall County Medical Society through its regular work in caring for patients injured in automobile accidents has observed the large number of deaths, temporary and permanent injuries to the people of this area, and

WHEREAS, we have noted that many of these accidents have involved repeat offenders, and

WHEREAS, we have noted alcoholic beverages have been a factor in a high percentage of these accidents, and

WHEREAS, we have noted that the law enforcement officers have discharged their duties efficiently and effectively, and

WHEREAS, we are desirous of stimulating public feeling against these accidents, and to publicize their disabling effects, and by so doing we hope to reduce the number of accidents by preventive measures and the fear of the law.

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia go on record as giving its wholehearted support to the Judicial Officers sitting in judgment on these cases and be it further resolved that those Judicial Officers be encouraged to render the strictest administration of justice.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the resolution presented concerning automobile accidents.

HOUSE OF DELEGATES ACTION — Adopted Resolution No. 18: Automobile Accidents as recommended by the Reference Committee on motion duly made and seconded.

It was moved by Chairman of Reference Committee No. 2 A. J. Waters and duly seconded that the report of Reference Committee No. 2 be adopted as a whole and it was so ordered.

Report of Reference Committee No. 4

CHARLES MCARTHUR, M.D., *Chairman*

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 4 met at 2:30 P.M. on May 18, 1959 in the Card Room, Bon Air Hotel, Augusta, Georgia. Members present were Charles McArthur, Cordele, Chairman; Rudolph Jones, Macon, Secretary, Marvin Greene, Monticello; W. A. Fuller, Augusta; W. H. Fulmer, Savannah; John P. Tucker, Moultrie; Jack Landham, Griffin; J. A. Greene, Athens; C. J. Roper, Jasper; and Mark Dougherty, Atlanta.

First District Councilor

CHARLES T. BROWN, M.D., *Guyton*

During the past year no special problems have arisen in the district. Your councilor has attended all meetings of the Council, and Vice-Councilor T. A. Peterson, has been very active and helpful in the affairs of the Council. The First District Medical Society meeting was held in Statesboro, Georgia, August 13, 1958, and an excellent program and good fellowship was enjoyed by all present. Lee Howard, Jr. of Savannah was elected President and David Robinson of Savannah was elected Secretary. A definite time for the annual meeting was establish, and program committee appointed. Eighteen counties comprise the First District with eight component medical societies. They are as follows:

Counties and Secretaries	December 31, 1958		December 31, 1957	
	MAG	AMA	MAG	AMA
Bulloch-Candler-Evans				
Kathryn S. Lovett,				
Statesboro . . .	19	14	21	18
Burke				
B. Lamar Murray,				
Waynesboro . . .	8	6	8	5
Emanuel				
H. W. Smith,				
Swainsboro . . .	7	6	6	6
Georgia Medical Society				
Lawrence Salter,				
Savannah . . .	145	132	149	135
Jenkins				
A. P. Mulkey,				
Millen	3	3	3	3
Screven				
Katrine R. Hawkins,				
Sylvania	6	5	6	5
Southeast Georgia				
John D. McArthur,				
Lyons	20	16	22	16
Tri Liberty-Long-				
McIntosh	2	2	2	2
	210	184	217	190

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends the approval of the First District Councilor report.

HOUSE OF DELEGATES ACTION — Adopted the report of the First District Councilor as recommended by the Reference Committee on motion duly made and seconded.

First District Vice-Councilor

T. A. PETERSON, M.D., *Savannah*

As Vice-Councilor, I have attended all meetings of Council during the 1958-59 term.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends the approval of the report of the First District Vice-Councilor.

HOUSE OF DELEGATES ACTION — Adopted the report of the First District Vice-Councilor as recommended by the Reference Committee.

Second District Councilor

GEORGE R. DILLINGER, M.D., *Thomasville*

The Second District Medical Society is functioning well. The Fall meeting in Thomasville was very well

attended. The scientific program was excellent, and among the honored guests were Dr. and Mrs. Lee Howard, Sr., MAG President.

Generally speaking, the local county societies are making progress, holding regular meetings and having good programs. I would report that as far as I am able to determine, organized medicine is functioning better than ever before in Southwest Georgia.

Thomas-Brooks Medical Society has extended an invitation to Grady County to form a joint society. We hope that Grady County will look with favor on the invitation.

Counties and Secretaries	December 31, 1958		December 31, 1957	
	MAG	AMA	MAG	AMA
Colquitt				
James T. Flynn,				
Moultrie . . .	17	14	16	13
Decatur-Seminole				
M. A. Ehrlich,				
Bainbridge . . .	17	15	17	15
Dougherty				
T. Gray Fountain,				
Albany	43	29	40	27
Grady				
John Ferrence,				
Whigham . . .	5	4	7	5
Mitchell				
A. A. McNeill, Jr.,				
Camilla	11	9	12	8
Southwest Georgia				
J. B. Martin,				
Edison	14	10	14	11
Thomas-Brooks				
Julian B. Neel,				
Thomasville . .	37	32	38	34
Tift				
H. K. Jarrett, Jr.				
Tifton	15	13	15	13
Worth				
H. G. Davis, Jr.				
Sylvester . . .	6	4	6	4
	165	130	165	130

REFERENCE COMMITTEE RECOMMENDATION—This Committee recommends the approval of this report. The Committee wishes to note that no report is available from the Vice Councilor of the Second District.

HOUSE OF DELEGATES ACTION—Adopted the report of the Second District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Third District Councilor

W. G. ELLIOTT, M.D., *Cuthbert*

The Third District held two medical meetings during 1958. The first one held at Lake Blackshear in May, was well attended and a good program was given. After the Scientific Program, a social hour and dinner was given on the shore of Lake Blackshear for the physicians and their wives. The Sumter County Society was host at this meeting.

The second meeting was held in Columbus and in conjunction with an annual Fall meeting of the Muscogee County Society. The Muscogee County Society provided a very good Scientific Program and a banquet at the Columbus Country Club that night. This was

held in October 1958. The meeting and banquet were both well attended.

There are two very active societies in the Third District: Muscogee, the largest and Sumter.

I think the Flint Society and the Peach Belt Society are somewhat active and have regular meetings. I am unable to get any information of much activity in the other five societies. One of these only lists one member and really should not be classified as a society.

My Vice-Councilor, Willis A. Jordan, has been very cooperative and has attended all the meetings of Council that I was unable to attend.

The number of members in each society and the number belonging only to the Medical Association of Georgia and the number belonging to the American Medical Association are listed below.

Counties and Secretaries	December 31, 1958		December 31, 1957	
	MAG	AMA	MAG	AMA
Ben Hill-Irwin				
Francis Ward,				
Fitzgerald . . .	9	8	11	10
Flint				
Joseph Christmas,				
Vienna	17	16	17	16
Peach Belt				
V. W. McEver, Jr.,				
Warner Robins .	17	17	16	16
Muscogee				
A. C. Hobbs, Jr.,				
Columbus . . .	104	98	104	96
Ocmulgee				
Reid Gullatt,				
Cochran	14	10	14	10
Randolph-Terrell				
R. B. Martin, III,				
Cuthbert . . .	13	9	13	9
Sumter				
Frank Wilson,				
Leslie	18	17	18	16
Taylor				
E. C. Whatley,				
Reynolds . . .	5	3	5	4
Wilcox	1	—	1	—
	198	178	199	177

REFERENCE COMMITTEE RECOMMENDATION—This Committee recommends the approval of the report of the Third District Councilor with the following exceptions and comment. Information reaching this Committee indicates that there are three very active societies in the Third District: Muscogee, Sumter, and Flint. The report is amended to read as follows: "There are three very active societies in the Third District: Muscogee, Sumter, and Flint. The Peach Belt Society is somewhat active and has regular meetings."

HOUSE OF DELEGATES ACTION—Speaker Goodwin recognized Frank Vinson, Peach Belt, who moved the deletion of the word "somewhat" in the Reference Committee Recommendation reading: "The Peach Belt Society is somewhat active and has regular meetings." This motion was duly seconded and approved. The House then adopted the report of the Third District Councilor as amended by the Reference Committee and further amended by the Vinson motion concerning the deletion of the word "somewhat" in the last sentence of the Reference Committee recommendation.

Third District Vice-Councilor

WILLIS P. JORDAN, M.D., *Columbus*

It has been my pleasure to attend one called meeting and two regular meetings of the Council, in the ab-

sence of the Councilor, W. G. Elliott. It has not become incumbent upon me to perform any further duties to date.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends approval of this report.

HOUSE OF DELEGATES ACTION — Adopted the report of the Third District Vice-Councilor as recommended by the Reference Committee on motion duly made and seconded.

Geriatrics

HARRY BRILL, M.D., *Chairman*

The first activity for the year of 1958 was attendance by the Chairman at the American Medical Association Planning Conference on Medical Society Action in the Field of Aging. This meeting was held in Chicago, September 13 and 14, 1958 and launched a broad positive health program for the aging population. The emphasis was on all aspects of the problem of old age, including the attitude of the public, financing of health care, the improvement of medical facilities, promotion of health maintenance programs, stimulation of medical and socio-economic research, and finally, leadership and cooperation by the profession in the community programs for senior citizens. This conference proposed that the state committees on aging adopt policies from the national level to specific circumstances of the state; keep informed as to activities of non-medical organizations, provide liaison with these groups, interpret policy, and provide information to the county medical societies and to help stimulate activity at the local community level.

The committee has held one meeting and is trying to define its scope and activity. It was voted to recommend to the Council and to the Constitution and By-Laws Committee that the name of the Medical Association Committee on Geriatrics be changed to the Committee on Aging and that the following purposes be written into the Constitution and Bylaws:

"The purposes of the MAG Committee on Aging shall be divided into three parts. In reference "aging" the purposes should include: (1) study of various aspects of the problems of aging, particularly as they relate to the provisions of medical care; (2) to initiate programs and activities which would provide the medical profession with pertinent information from such studies; and (3) to assume a leadership role in research and in adding to community understanding of the aging process and its implications to the individual. In reference to the "aged" the purpose should include: (1) to be informed on the problems which exist or may arise in the area; (2) to initiate activities and cooperate with other groups of activities designed to meet these problems; and (3) to inform the profession of public health problems and activities and of their responsibilities in this field."

In order to provide a broad base of activity for this committee, a letter was drafted to each county medical society recommending the establishment of a local committee on aging. It is further recommended that these committees be established according to the suggested guide provided by the American Medical Association. When the appointment of the county committees is completed it is hoped that a state meeting of committee chairmen can be held to stimulate interest

and work on the individual problems as they exist in the various communities of the state.

Liaison has been established with the Division of Geriatrics of the State Health Department and two meetings have been held. Further cooperation and work is desirable, particularly in the fields of health studies, nursing homes, and institution supervision. Advisory and consultative services to the county medical societies as recommended by the 1957 Chairman will be undertaken when county committees on aging are appointed. Close contacts with other committees of the Medical Association is desirable and liaison with the Insurance and Economics Committee has been established. This committee feels strongly that the activation of the indigent care program of the Georgia State Department of Public Health would assist tremendously in improving medical care for the rather large number of elderly people with extremely limited incomes.

In the coming year it is hoped that more specific goals can be set and individual problems met in this enormous field.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends the approval of the Geriatrics report with the following exceptions and comments. It is recommended that the following portion of the report be deleted: "This Committee feels strongly that the activation of the Indigent Care Program of the Georgia State Department of Public Health would assist tremendously in improving medical care for the rather large number of elderly patients with extremely limited income." It is further recommended that clarification of this paragraph by the Geriatrics Committee be achieved in future reports.

HOUSE OF DELEGATES ACTION — Adopted the report of the Geriatrics Committee as amended by the Reference Committee on motion duly made and seconded.

History and Vital Statistics

CARL C. AVEN, M.D., *Chairman*

The Committee has met on several occasions and reviewed the material on the history of Georgia medicine prepared by the late Calvin Weaver. This material is now in the hands of a qualified professional writer and we hope to have definite recommendations to make at the time of the meeting of the House of Delegates in Augusta. This will be presented in the form of a supplementary report.

The other members of the committee who have served with me are Morgan Raiford and Herbert Alden, both of Atlanta.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends acceptance of this report as information.

HOUSE OF DELEGATES ACTION — Adopted the recommendation of the Reference Committee concerning the report of the History and Vital Statistics Committee.

Insurance and Economics

DAVID R. THOMAS, M.D., *Chairman*

The work of this committee has continued its responsibility in co-ordinating its work with the Medical Association of Georgia and the overall insurance and economics problems of the members of the Association. The members of this committee have been active in their efforts and often through great sacrifice have attended the meetings that have been necessary. It is only through the efforts of all the members of this

committee that we are able to accomplish our mission.

The cooperation of Council and the Executive Committee of Council has been most gratifying. Mr. Krueger, Mr. Kiser, and their staff have been most cooperative and interested in the affairs of this committee and have been of inestimable assistance. Mr. Krueger and Mr. Kiser have kept the committee advised and handled the administrative matters and executed the policies directed by the committee very efficiently.

John Elliott and Mr. H. B. Collidge of Savannah have continued to handle the unlisted procedures and the unusual cases that continue to come to the attention of this committee. The handling of this vital function of the committee is most efficiently accomplished through their efforts. I would again express the opinion that all expense in connection with this function of the committee is most efficiently accomplished in Georgia and included in the budget of the Insurance and Economics Committee.

Mr. Sheffield Owen of Atlanta has been appointed as chairman of the Health Insurance Council for the State of Georgia, and has been most cooperative and helpful in advising the Insurance and Economics Committee. The cooperation and assistance of the Insurance Industry, both commercial and Blue Cross and Blue Shield, are acknowledged.

Group Life Insurance: Our group life insurance program continues to operate satisfactorily with the estates of our deceased colleagues having benefited from this insurance. As you know, new members must participate within six months after becoming members of the Association in order that they can avail themselves of this insurance without proof of insurability. It is important that the number of participating physicians be maintained for this society to have this group coverage, and it is urged that those who are interested participate if they so desire.

Catastrophic Hospital-Nurse Insurance: We are experiencing a very high return on this insurance program as the Provident Life and Accident Insurance Company, who is handling this program for us, is experiencing a loss ratio that is extremely high at this time. Your committee feels that this is very good catastrophic coverage, as coverage cannot be obtained through any other source to as good advantage as through this group policy with the Medical Association of Georgia. It is the feeling of the Insurance and Economics Committee that some form of catastrophic insurance should be encouraged for everybody. This is the type of insurance that so often is found to be necessary to avoid financially embarrassing situations for all citizens as well as physicians.

Health and Accident Disability Insurance: Health and Accident Insurance is sponsored by the Medical Association of Georgia on a group basis for its members and is carried in two companies, the Provident Life and Accident Insurance Company and the Commercial Insurance Company. In this insurance we have group policies that are of value to the physicians for loss of time from work, whether due to illness or accident, and it is believed that self-employed people find this form of insurance to be a necessity. It is hoped that within the next year that both of these policies can be reviewed and the coverage made more liberal as well as arrangements made for greater coverage for those who find it

necessary. It is suggested that the members of the Medical Association of Georgia, who participate in this type of program, review their policies to see that their coverage is adequate and that the coverage obtained is not in excess of that which is allowed by some insurance companies that are selling this type of insurance on an individual basis, and at times in other group policies. The members should again be reminded that they should check with their accountants in order that they might take advantage of income tax deduction features, remembering that income received from policies that you are taking an income tax deduction on becomes accountable as income should you experience a disability, and that which is not deducted for income tax purposes is received as tax-free insurance; this is to be handled on an individual basis as deemed wise by the individual concerned.

The Georgia Plan: Though the Georgia Plan Insurance was revised in 1957, the participation in this plan by the members of the Medical Association of Georgia has been very limited. For this plan to be a success, greater participation and an understanding of the objectives of this plan by the members of the Medical Association of Georgia is necessary. The Georgia Plan is a service plan only to limited income groups and individuals, and the insurance carried may serve as an indemnity plan for those individuals having a greater income than that allowed under the Georgia Plan.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends acceptance of this report as information.

HOUSE OF DELEGATES ACTION — Adopted the recommendation of the Reference Committee concerning the report of the Insurance and Economics Committee.

Medical Defense

CHARLES S. JONES, M.D., *Chairman*

During the year 1958 there was a definite rise in the incidence of professional liability claims which came to the attention of this Committee. The cooperative effort now being made by the Saint Paul Mercury Indemnity Company, working closely with the Executive Office of the Medical Association of Georgia, is producing very gratifying results. One of the most interesting features that is coming from this association between the insurance company and our medical society is an increasing knowledge of the basic ingredients of a professional liability claim. Two points stand out at this time. In almost every claim either one or both of the errors which are listed below have been made. These mistakes are:

1. Improper and injudicious talk and advice by one doctor concerning another doctor's work. Very frequently this advice or criticism is rendered without even a casual knowledge of the circumstances involved. All doctors in Georgia should be constantly aware of the fact that they should not criticize or comment upon the work or results of another doctor unless they are thoroughly conversant with the details involved and the circumstances surrounding which might appear to be "a less than ideal" result.
2. The second ingredient is a deterioration of doctor-patient relationship. It has long been understood that the doctor and the patient

involved in professional liability litigation are not on the friendliest of terms. However, our experience would indicate strongly that this unpleasant relationship developed early in the course of such a disagreement, and might well be one of the basic causes for the difficulty. It seems superfluous to say that every doctor should be patient and solicitous of anyone under his care who is not entirely satisfied with treatment which he, or she, has obtained. The doctor's interest and concern for a dissatisfied patient may well be the ingredients which prevent a most distressing professional liability suit.

The annual review of experience with our insurance carrier, the Saint Paul Mercury Indemnity Company, has been held in Atlanta. Some three hours were spent discussing all features of the program and details of the insurance coverage which we have. As most doctors now realize, we have an advantageous premium rate which will continue for at least another year. The insurance company has been requested to finance an educational program which would be used to help doctors in Georgia to prevent, rather than defend, malpractice claims. We are hopeful that this will contribute to a reduction in the number of claims filed.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends acceptance of this report as information.

HOUSE OF DELEGATES ACTION — Adopted the recommendation of the Reference Committee concerning the report of the Medical Defense Committee.

Professional Conduct

W. F. REAVIS, M.D., *Chairman*

The Professional Conduct Committee met on Sunday, September 21, 1958 at the Academy of Medicine, Atlanta, to consider two cases. The physicians in each case were present and also the complainant in one case. The Committee went into considerable detail in investigating these two cases. One case was settled by the mediation efforts of the Committee. It was felt that the two parties will be able to get together to settle their differences amicably.

The other case was at the time pending in federal court and the Committee recommended that action be taken by the county medical society when court action was completed.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends acceptance of this report as information.

HOUSE OF DELEGATES ACTION — Adopted the recommendation of the Reference Committee concerning the report of the Professional Conduct Committee.

Blood Banks

LESTER FORBES, M.D., *Chairman*

The Blood Bank Committee of the Medical Association of Georgia has been inactive during the past few months due to personal commitments of the Chairman of the Blood Bank Committee. However, some progress has been made in that representatives of the Blood Bank Committee have met with representatives from the Georgia State Public Health, The Atlanta

Regional Chapter of the American Red Cross, and representatives from the medical technologists to form a joint committee to study the problems of blood banking in the State of Georgia. Plans of this committee are to outline a program of joint cooperation from these groups to try to disseminate knowledge, advance techniques, and provide a uniform method of blood banking throughout the State of Georgia. The Executive Committee will be kept informed of the progress of this committee and will be called on in the future for support of the needs of the recommendations of this committee.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends acceptance of this report as information.

HOUSE OF DELEGATES ACTION — Adopted the recommendation of the Reference Committee concerning the report of the Blood Banks Committee.

School Child Health

GRADY BLACK, M.D., *Chairman*

The activities of this committee has been somewhat impaired as the chairman, Virginia McNamara is now on educational leave of absence. The new chairman has not had an opportunity to meet with the other members of the committee prior to this report.

It is planned to consider attempting to secure passage of inclusive driver training legislation for the State.

It is the further feelings of the committee to attempt to get the schools of the State of Georgia to follow recommendations of the National Conference on Fitness for Secondary School Youths in requiring all students in grades seven to 12 to receive an hour a day of health, safety, and physical education.

This committee hopes to aid in pushing regulations to be followed concerning numbers of students on school buses, as well as encouraging the use of capable and well trained bus drivers.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends acceptance of this report as information.

HOUSE OF DELEGATES ACTION — Adopted the recommendation of the Reference Committee concerning the School Child Health Committee report.

Inter-Agency TB Report

WALTER S. DUNBAR, M.D., *Chairman*

The Georgia Inter-Agency TB Committee was founded in June, 1957 by a group of Georgia citizens interested in improving the over-all management of the tuberculous patient. The committee consists of two representatives from each of 13 agencies. It meets approximately six times each year. Each agency has a one-year and a two-year member on the committee. A new member is appointed by each agency annually to replace the expired term of the one-year representative. The secretarial responsibility of the committee is performed by the Georgia TB Association.

The committee has representatives from the following agencies:

Georgia Department of Public Education
Emory University School of Medicine
Georgia Department of Public Health

Georgia Hospital Association
Georgia League For Nursing
Medical College of Georgia
Medical Association of Georgia
Georgia Board of Examiners of Nurses for
Georgia

Georgia State Nurses Association
Georgia Tuberculosis Association
Veterans Administration
Georgia Veterinary Medical Association
Georgia Department of Public Welfare

Carl C. Aven and Walter H. Dunbar are MAG representatives to the Committee. Dr. Dunbar was 1958 chairman. Mr. George Sumerau of Augusta is the present chairman.

The purpose of the committee is to eliminate overlapping and duplication of services and activities of member agencies. The group is not primarily an action group, but it functions in an advisory capacity. The problems that arise in the handling of TB are discussed at the committee meetings and possible solutions to the problems are reviewed. The educational impact on the committee members themselves by this exchange of information is invaluable and leads to smoother coordination of the agencies themselves.

Problems that have been tackled by the group include that of the tuberculous patients who leave Battey State Hospital against medical advice, the timing of vocational rehabilitation during the patient's convalescence, the use of the tuberculin skin test in mass surveys, the granting of welfare assistance to TB patients and their dependent families, and other subjects.

One of the initial discussions centered around the timing of rehabilitation to patients. A direct result of the committee's discussion of the program was placement of a full-time rehabilitation counselor at Battey State Hospital. Another achievement resulted from a discussion of welfare benefits. Coordination between the local health departments and state welfare department was improved; the decision as to degree of disability and as to payment of welfare benefits of the patient was thereafter handled more expediently.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends acceptance of this report as information.

HOUSE OF DELEGATES ACTION — Adopted the recommendation of the Reference Committee concerning the report of the Georgia Inter-Agency TB Committee.

Resolution No. 6 Release of Information

SOUTHWEST GEORGIA MEDICAL SOCIETY

WHEREAS, recently several members of our society have been requested by insurance company personnel for medical information concerning various patients over the telephone without previously furnishing the physician with the written authorization of the patient, and

WHEREAS, this society feels that this custom infringes on the confidential relationship which exists between physician and patient and possibly will cause the physician to become legally liable to the patient because of this unauthorized release of information,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia instruct the Insurance and Economics Com-

mittee to contact the various insurance companies doing business in Georgia with the request that they instruct their personnel to cease this type of solicitation at once.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends disapproval of this Resolution.

HOUSE OF DELEGATES ACTION — Speaker Goodwin recognized Harold P. McDonald, Fulton County, and Mason Lowance, Fulton County, who discussed this Resolution. On motion made by Harold P. McDonald, Fulton, and duly seconded, it was moved that the House of Delegates disapprove this Resolution as recommended by Reference Committee, but physicians should be advised about release of information as it pertains to the physicians' Code of Ethics. This motion was adopted.

Resolution No. 7 Industrial Insurance Forms

SOUTHWEST GEORGIA MEDICAL SOCIETY

WHEREAS, there are numerous insurance carriers selling "Weekly Sick & Accident" Insurance to the people of Georgia—especially, the colored population, and

WHEREAS, all of these Industrial Type Insurance Companies use a different type of claim form which must be filled out at weekly intervals to establish a claim for the insured and most of these claim forms are unnecessarily complicated and require needless waste of the physician's time, and

WHEREAS, this problem is an especially obnoxious one for the general practitioners of the State .

NOW THEREFORE BE IT RESOLVED, that the House of Delegates instruct the Insurance and Economics Committee to work toward the adoption of a standard form for use with all such insurance companies incorporating only the absolutely necessary information and request that authority be granted various employees of the physician be allowed to sign such forms in behalf of the physician.

An acceptable and highly desirable standard form is hereby submitted incorporating the following information only: name, address, date first treated, primary diagnosis, complications (if any), date patient should be able to go to work, signature of physician.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends the approval of this Resolution with the following amendments: 4th paragraph to be amended to read as follows:

"NOW THEREFORE BE IT RESOLVED that the House of Delegates instruct the Insurance and Economics Committee to work toward the adoption of a standard form to be used by all such insurance companies incorporating only the absolute necessary information."

It was further recommended that this resolution be referred to the Council Committee on Standardization of Insurance Forms.

HOUSE OF DELEGATES ACTION — Adopted Resolution No. 7: Industrial Insurance Forms as amended by the Reference Committee with their additional recommendation on motion duly made and seconded.

It was moved by Chairman of Reference Committee No. 4 Charles McArthur and duly seconded that the report of Reference Committee No. 4 as amended be adopted as a whole and it was so ordered.

Report of Reference Committee No. 5

MAJOR FOWLER, M.D., *Chairman*

(The following reports as presented to this Reference Committee are printed in full with the reference com-

mittee's recommendation and the action pursuant to it taken by the House of Delegate.)

Reference Committee No. 5 met at 2:30 P.M., May 18, 1959, Room 462, Bon Air Hotel, Augusta, Georgia. Members present were: Major Fowler, Atlanta, Chairman; Leo Smith, Waycross, Secretary; Lester Rumble, Atlanta; E. C. McMillan, Macon; Alex Little, Valdosta; Wayne Harris, Royston; and Robert McGahee, Atlanta.

Fourth District Councilor

VIRGIL WILLIAMS, M.D., *Griffin*

The Councilor of The Fourth District has attended all regular and called meetings of the Council during the past year.

The Councilor has visited most of the counties in the Fourth District at some time during the year in order to determine the status of organized medicine in the District. Numerous informal consultations have been held with members of the association residing in the Fourth District concerning matters of policy, organization, and ethics.

The Councilor has been ready at all times to advise on problems pertaining to the office. Clayton-Fayette

Counties and Secretaries	December 31, 1958		December 31, 1957	
	MAG	AMA	MAG	AMA
Clayton-Fayette				
Wells Riley, Jonesboro	4	4	4	4
Coweta				
J. O. St. John, Newnan	19	7	19	5
Lamar				
S. B. Traylor, Barnesville	4	4	4	4
Meriwether-Harris				
J. W. Smith, Jr.,				
Manchester	15	8	1	6
Newton				
J. W. Purcell, Jr.,				
Covington	11	10	14	11
Spalding				
H. A. Foster, Griffin	38	32	39	33
Troup				
J. R. Turner, LaGrange	39	33	33	32
Upson				
Doug Head, Jr.,				
Thomaston	17	12	16	11
	147	110	145	106

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends the approval of the Fourth District Councilor's report.

HOUSE OF DELEGATES ACTION — Adopted the report of the Fourth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fifth District Councilor

J. G. McDANIEL, M.D., *Atlanta*

The Fifth District Medical Society has had one meeting since the last Annual Session of MAG. It was well attended. We had an excellent program, with Dr. Leon Schiff, of the University College of Medicine, Cincinnati, Ohio as the principal speaker. The title of his presentation was "The Clinicians Approach to Liver Disease."

Your Councilor and Vice-Councilor made reports at this meeting. I am happy to report that I attended all meetings of Council and all meetings of the Executive Committee of Council during the past fiscal year.

The Fifth District is pleased in that we have had no problems of magnitude to arise during the year. Both Fulton County Medical Society and DeKalb County Medical Society are growing rapidly and doing good work.

The Vice-Councilor, Charles S. Jones, did an excellent job on Medicare, and continues to do splendid work on the insurance and other committees.

Counties and Secretaries	December 31, 1958		December 31, 1957	
	MAG	AMA	MAG	AMA
DeKalb				
R. I. Gibbs, Jr., Decatur	82	73	72	67
Fulton				
Thos. J. Anderson, Jr.,				
Atlanta	875	702	861	704
	957	775	933	771

REFERENCE COMMITTEE RECOMMENDATION — This Committee approves the report of the Fifth District Councilor and commends him for the work done this year.

HOUSE OF DELEGATES ACTION — Adopted the report of the Fifth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fifth District Vice-Councilor

CHARLES S. JONES, M.D., *Atlanta*

There seems to be no end to serious and pressing problems which must be considered by your Council. The year 1958 has been both active and productive for the effort which has been expended by Council members. As has been liberally covered in recent newspaper articles, the Governor of Georgia has worked closely with the Council of the Medical Association in attempting to solve the basic problems involved in our State Mental Institution.

A second and urgent problem at present before your Council is a program for Health Care for the Aging. This is a part of a national program which is being urged by the American Medical Association, in an effort to forestall passage of the Forand Bill. This bill, as most doctors realize, would place every recipient of Social Security under a medical program totally financed by the government. We are hopeful that a satisfactory program can be worked out which will forestall such a bill.

As Vice-Councilor it has been my privilege and pleasure to serve with the dedicated men who are giving freely of their time in the interest of organized medicine in Georgia.

REFERENCE COMMITTEE RECOMMENDATION — This Committee approves the report of the Fifth District Vice-Councilor and recommends that Council take an active part in the National Program of the Health Care of the Aging.

HOUSE OF DELEGATES ACTION — Adopted the report of the Fifth District Vice-Councilor as recommended by the Reference Committee on motion duly made and seconded.

Sixth District Councilor

HENRY H. TIFT, M.D., *Macon*

The Sixth District Medical Society met at the Macon Hospital, Macon, Georgia, on December 3, 1958. Charles Jordan, of Eatonton, presided and an excellent scientific program was presented by Joe S. Robinson, Oscar Spivey, J. P. Woodhall, C. L. Ridley, Jr., all of whom are members of the Sixth District

Medical Society; and Claude Starr-Wright and William Moretz, visiting speakers from the Medical College of Georgia.

Following the scientific meeting, the following officers were elected for the coming year: president, W. P. Roche, Jr.; vice-president, H. D. Allen, Jr.; secretary-treasurer, Waddell Barnes. George Alexander, of Forsyth, was nominated by the Society for Sixth District Councilor and William H. M. Weaver, of Macon, was nominated for Vice-Councilor.

It was voted to have the next meeting of the Sixth District Medical Society in Forsyth, Georgia, on April 8, 1959.

Membership in the Sixth District Medical Society is as follows:

<i>Counties and Secretaries</i>	<i>December 31, 1958</i> <i>MAG</i>	<i>December 31, 1957</i> <i>AMA</i>	<i>MAG</i>	<i>AMA</i>
Baldwin				
A. S. Sanchez, Eatonton	32	15	29	13
Bibb				
Calder B. Clay, Jr., Macon	152	137	152	139
Jasper				
E. M. Lancaster, Shady Dale	4	3	4	3
Jefferson				
John J. Pilcher, Wrens	7	3	8	5
Laurens				
John A. Bell, Jr., Dublin	24	10	25	10
Washington				
M. W. Hurt, Sandersville	12	—	12	11
	<hr/> 231	<hr/> 168	<hr/> 230	<hr/> 181

REFERENCE COMMITTEE RECOMMENDATION — This Committee approves the report of the Sixth District Councilor.

HOUSE OF DELEGATES ACTION — Adopted the report of the Sixth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Sixth District Vice-Councilor

GEORGE H. ALEXANDER, M.D., *Forsyth*

No report—see report of the First Vice-President of Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION — No report as Vice-Councilor was submitted. Please refer to the report of the First Vice-President.

HOUSE OF DELEGATES ACTION — Adopted the recommendation of the Reference Committee concerning the referring of the action of the Sixth District Vice-Councilor to the Sixth District Vice-Councilor's report as First Vice-President of the Association.

Hospital Relations

MILFORD B. HATCHER, M.D., *Chairman*

The Georgia Hospital-Medical Mediation Council has been properly organized and is functioning with quarterly meetings. A letter has been sent out to hospital administrators, medical directors, hospital chiefs of staff, county medical society presidents and secretaries, hospital trustees, and medical specialty society officers, stating the Council is functioning and is on call whenever its services might be of help in disputes at the local level. This letter was signed by the President of the Medical Association of Georgia, President of Georgia

Hospital Association, and President of Georgia Association of Hospital Governing Boards.

The object of the Council is: (1) provide upon request advisory or mediation services to administrators, physicians, and trustees when problems or working relations arise, and (2) to carry on an educational program for improvement of professional and administrative standards in Georgia hospitals.

This committee feels that when hospitals, depending upon their size, attain certain professional and administrative standards, they should be given proper recognition. The exact standards were worked out by a joint committee of the Medical Association of Georgia, Georgia Hospital Association, and the Georgia Association of Hospital Governing Boards, and an educational program is to be carried forward and an attempt made to get every hospital in the State of Georgia to approach this standard. It is hoped by this method that the standards of hospitals in the State of Georgia will be kept at a very high level.

The professional standards as proposed for the hospitals are enclosed for review and approval. They have been tentatively approved by the Hospital Relations Committee of the Medical Association of Georgia and the Georgia Hospital-Medical Mediation Council. It is hoped that the various groups concerned can approve these standards and that this program can be started as of January 1, 1960. It is requested that the program be approved in its entirety, and those hospitals qualifying will be given proper recognition. It is requested that finances be authorized to support the Medical Association of Georgia's proportionate amount for this program.

The Committee reviewed the report of the Georgia Commission on Nursing, W. S. Dorrough, Chairman, which was sent to the Honorable Marvin Griffin on December 22, 1958. This Commission was set up as a result of Resolution No. 7, MAG House of Delegates action, Savannah, Georgia, 1957.

The Hospital Relations Committee requests that the MAG House of Delegates approve or make further recommendations concerning the report of the Georgia Commission on Nursing, and requests that this report, as approved, be referred back to the Hospital Relations Committee for action. It further requests that the MAG Delegates to the AMA present this report to the House of Delegates of the American Medical Association for the action of the House of Delegates of the AMA.

The Hospital Relations Committee has been working on the problem of paramedical recruitment, but finds this a rather complex problem. It is attempting to correlate all other agencies working on this problem in the hope that something concrete will be offered during the next year.

Recommendation: Financial assistance to put these programs into action. (Approximately \$2,000.00).

REFERENCE COMMITTEE RECOMMENDATION — This Committee approves in principal the report of the Hospital Relations Committee with the recommendation that the report of the Georgia Commission on Nursing be referred to the Committee on Hospital Relations for their further study and evaluation and report back to the House of Delegates. It was also recommended that financial assistance necessary to implement these programs be referred to the Finance Committee of Council.

HOUSE OF DELEGATES ACTION — Adopted the report of the Hospital Relations Committee as amended by the Reference Committee on motion duly made and seconded.

Industrial Health Committee

T. A. PETERSON, M.D., *Chairman*

This committee met with the entire Workman's Compensation Board in an effort to gain some increases in our fee schedule. Our request was not approved, but we feel that we have gained knowledge of how to approach this matter at a later date.

As Chairman of this Committee, I attended the AMA Industrial Health Committee meeting held in Cincinnati, Ohio, February 17 to 19, and will attend the National Health Forum to be held in Chicago, Illinois, March 17 to 20.

I wish to thank each member of this Committee for their wonderful help and cooperation.

REFERENCE COMMITTEE RECOMMENDATION—This Committee approves the report of the Industrial Health Committee and commends them for their work.

HOUSE OF DELEGATES ACTION—Adopted the report of the Industrial Health Committee as recommended by the Reference Committee on motion duly made and seconded.

Maternal and Infant Welfare Committee

EUGENE GRIFFIN, M.D., *Chairman*

By the time this report is published, the committee will have had at least two formal meetings of the maternal section, and one informal meeting of the perinatal section between the chairman, Dr. Sharpley and the secretary. A proposed organizational chart showing the relationship and composition of the two sub-committee sections, together with proposed additional membership will have been submitted to the council.

The work of the maternal section has been materially implemented by the addition of a full-time obstetrician to the State Health Department staff. The operation of this section had previously been hampered by lack of time on the part of its membership to follow through. Even though cases had been reviewed by the committee, it was difficult to prepare all the needed letters. Also, it has been possible to develop additional information.

While the maternal mortality rate continues to decrease each year, case studies reveal that there remains a great deal of room for improvement. Ignorance on the part of the patient and family, together with problems of hospitalization on the basis of economics, pose a major problem. Figures show that the risk of maternal death is two and one half times as great in the home as in the hospital. Physicians delivered only 2,980 mothers in the home in 1957, another 12,000 were delivered by lay-midwives. There were 87,000 delivered in hospitals.

Non-white deaths accounted for 70, and the white for 36 of the 106 deaths in 1957. In the group of unwed mothers, the maternal death rate was nearly three times as high. Irrespective of parity, there was a much higher death rate in the women over 30, the rate being 20.5/10,000 live births from 30-39 years of age, a total of 47 women, and 25.2/10,000 live births in the group aged 40 and over, a total of 12.

The maternal section will have reviewed over 100 deaths by the end of the year, and appropriate educational suggestions will be transmitted to those concerned, including physicians and local health department.

This section sponsored the article and reprints from

the *Journal* on "Suggestions to Physicians Signing Certificates of Safety for Delivery by a Midwife." It also went on record as favoring encouragement of local physician groups to cooperate with local health departments in developing provisions for planned medical care of all prenatals. It was felt that clinics would probably have to be organized to those counties where there were more than 50 lay midwife deliveries, and where there is at present no planned provision for medical care. Other problems reviewed were the counties lacking in physicians and/or hospital facilities. Tentative recommendations were developed for planning in the three types of situations now existing, i.e. (1) sufficient hospital beds and bassinets, and sufficient number of physicians; (2) sufficient hospital beds and bassinets, but shortage of physicians; (3) inadequate facilities for hospitalization and shortage or lack of physicians. Since in certain areas there actually exist a shortage of professional personnel and/or hospital beds, there was discussion of the hospital-health department nurse-midwife program. There was also discussion of the need for new midwives and the responsibility of the State Health Department for training them.

In the field of perinatal mortality and maternal care, there was concern over the omission, on the new birth certificate, of medical items. These have meaning. We are told, however, that the State Health Department plans to do sampling. An explanation is being requested. In the meantime, the committee understands that the State Health Department has requested outside assistance from a statistician who specializes in information related to maternal and child health activities.

The committee regrets the resignation of Charles Mulherin as chairman, recognizing his years of service. Eugene Griffin is the new chairman, and Drs. LeRoy, McKemie, and Bryans are new appointments to replace those who have become unable to act. There is still one vacancy in obstetric representation. As the perinatal section becomes more active, others may be added.

REFERENCE COMMITTEE RECOMMENDATION—This Committee approves the report of the Maternal and Infant Welfare Committee and commends them for their work this year.

HOUSE OF DELEGATES ACTION—Adopted the report of the Maternal and Infant Welfare Committee as recommended by the Reference Committee on motion duly made and seconded.

Medical Education

CHARLES S. STONE, M.D., *Chairman*

In the fall of 1958, letters were sent to the committee members, consisting of R. C. McGahee and Dean O'Rear of the Medical College of Georgia, requesting suggestions and comments of pertinent interest.

In January 1959, Dean O'Rear was visited in Augusta, and some educational techniques were discussed.

On February 7 through 10, the 55th Annual Congress on Medical Education and Licensure met in Chicago, and was attended. Some excellent papers were presented and will be published in the next few months by the American Medical Association for those persons interested.

On February 20-21, the Southeastern Clinical Club met in Birmingham, Alabama, and many representatives of Tulane, L.S.U., Vanderbilt, University of Alabama Medical School, and Emory University School of

Medicine, together with some practicing physicians attended. Mutual problems concerning educational trends were discussed.

Many papers have been heard, much formal and informal conversation has been pondered, and much confusion is apparent. However, a few generalizations may be justified:

1. **SPECIALISM** in medicine is increasing of necessity because of the "search for excellence"—but more **GENERALISM** is needed to take care of the public.

2. Socialistic trends are apparent in many directions at federal, state, and local levels.

3. "Big Business" medicine also is gaining in some unusual spots such as John L. Lewis' coal mining hospitals where residents in medicine are paid as much as \$1,000.00 per month, and hospital per diem costs have sky-rocketed.

4. Medical educational processes must somehow be shortened without loss of quality, so that a physician can begin his practice at an earlier age, otherwise soon we will all be "half-dead" before we start.

5. Fifty-five per cent of intern and resident training is now being carried on in "teaching hospitals" that have no university affiliation. These institutions are trying constantly to improve themselves through such organizations as the American Association of Directors of Medical Education, and much progress is being made. This area is vital in proper patient care as these "non-university hospitals" are responsible for 75 per cent to 80 per cent of all hospitalized patients in this country.

From the above few generalizations it can be seen that many problems exist. The intelligence and understanding of all of us in the medical profession will be needed to further raise the standards of medical education and its object, **BETTER PATIENT CARE**.

REFERENCE COMMITTEE RECOMMENDATION — This Committee approves the report of the Medical Education Committee and commends them for their work.

HOUSE OF DELEGATES ACTION — Adopted the report of the Medical Education Committee as recommended by the Reference Committee on motion duly made and seconded.

Veterans Affairs

CHARLES R. ANDREWS, M.D., *Chairman*

The Veterans Affairs Committee is attempting to largely work along the lines of the MAG-VFW Liaison Committee this year. It is felt that some approach may be made to our problem by having discussions with one of the veterans' organizations with hope that some positive basic statements may be presented which will put us in a better position to continue our program.

It is still the opinion of the committee that we should continue our work along the lines set forth in the past. It is felt that no new VA Hospitals should be constructed in Georgia. We certainly feel that there are adequate beds as far as physical set up is concerned, but that they are not apportioned properly and certain phases are not staffed properly. I would like to repeat that there is no criticism of care for service connected cases, however, much remains to be done to improve handling of non service connected cases. It is believed that these latter cases are primarily a responsibility of the local communities, either city, county, or state. Bed

capacities of the Veterans Hospitals in the State of Georgia remain about the same as last year.

While it is difficult to combat such a juicy plum, politically, it is important for us to continue our efforts toward guarding our principles of the free enterprise of American medicine and this is a committee which must continue to operate.

REFERENCE COMMITTEE RECOMMENDATION — This Committee approves the report of the Veterans Affairs Committee.

HOUSE OF DELEGATES ACTION — Adopted the report of the Veterans Affairs Committee as recommended by the Reference Committee on motion duly made and seconded.

Rural Health

ALBERT L. MORRIS, M.D., *Chairman*

The Committee on Rural Health has held two meetings during the interim under the present Chairman. These meetings have been well attended, both by the members of the Committee, and the members of the Advisory Committee.

Under projects completed we should like to mention the following:

Junior Day Program: This has been taken over by the Georgia Academy of General Practice, and is now functioning in each medical school on a yearly basis.

Weekly Newspaper Health Column: This was instituted by the Rural Health Committee and Public Relations Committee and has been realized in "Doc MAG Says" which is furnished the various newspapers in the State.

Physician Placement: This is a function carried out by the headquarters office under the direction of the Rural Health Committee. It furnishes the names of available physicians to interested communities and also furnishes information of communities to interested physicians.

Poison Centers and Poison Pamphlet: The Rural Health Committee is cooperating with the Public Health Department of the State of Georgia in aiding the establishment of Poison Centers at various locations in the State. In the Fall of 1958 a poison pamphlet was distributed to the physicians of Georgia as a part of this program.

Health Record, Card, and Pamphlet: Some 10,000 AMA health records and pamphlets have been placed with the rural families through the cooperation of Miss Lucille Higginbotham, Educational Specialist, Agricultural Extension Service, University of Georgia.

4-H Club Health Form: Through the efforts of Charles McArthur cooperating with the 4-H Club officials, a standardized health form has been devised for the use of various summer camps in the State. A copy of the form is enclosed with this report, and it is the hope of the Rural Health Committee that the official approval of the Board of Directors will be given.

Health Insurance Pamphlets: Some 18,000 pamphlets are being prepared for distribution to the rural people of Georgia, explaining in every day language, the different types of Health and Accident Insurance; their nomenclature, and standard provisions. In addition, giving a short check form, where provisions can be cross-checked. Through this program the Committee hopes to help correct the vast misunderstanding of Health and Accident Insurance.

Movie Film Library: A pilot project has been insti-

tuted in Georgia, whereby movie films from AMA pertaining to lay education have been secured for distribution by the Agricultural Extension Service at the University of Georgia. These films are obtained on a six months loan basis. It is hoped that this program can be greatly enlarged in the coming months.

We mention briefly the following projects which, although still of great interest, have been only partially successful with our Committee.

- 1) *Clarkesville Laboratory School*: This project is for the training of practical laboratory technicians. These trainees are to be given short intensive courses which will enable them to perform minor laboratory work in doctors' offices, and other helpful duties. You will recall that this program has met with dissent from the Association of Registered Technicians. Also the Medical Association of Georgia has appointed a committee for investigation. It is our understanding that this course would be accepted by the school when and if a qualified teacher can be secured.
- 2) *Hospital Ministerial Service*: Under the guidance of Katrine Hawkins, an extensive survey of the hospitals in Georgia having 15 beds or more was made. One hundred sixty-six questionnaires were sent and 74 or 44 per cent response was received. The committee voted to aid and assist the Association Committee on Ministerial Liaison in this field.
- 3) *Paramedical Recruitment Pamphlets*: Still of vast interest to the committee, this project has been taken over by the Woman's Auxiliary of the MAG in conjunction with the Committee on Public Relations. The Rural Health Committee wishes to commend their efforts and desires to help if possible.

FUTURE PLANS

1. Enlarge the Advisory Committee: It is the desire of the Rural Health Committee to invite membership from the Woman's Auxiliary of MAG, the Georgia Association of Dentistry, The Georgia Association of Veterinary Medicine, and the State Department of Public Health, to become part of the advisory committee. This is according to the plans of the American Medical Association.

2. Undertake a program to help educate the rural people of Georgia to the different animal diseases that are transmitted to man.

3. To continue the program of education on problems of poisons used on the farm and their effects on people.

4. To help attack the problems of the aged in rural communities.

Our greatest efforts shall probably be made in the latter field of geriatric care. We cannot fail to recognize that the old and sick down on the farm, are just as much of a problem as those in the city. In fact, probably more of a problem, since facilities and medical care are fewer in the rural areas than in the metropolitan areas. It has been said that government naturally moves to occupy a void. In spite of Social Security measures and other socialistic services provided by the government today, the problem of the aged presents the largest void. Adequate care, home versus institutional; ways and means; occupational therapy; plus many more demand immediate attention from the

medical profession. We are speaking not necessarily of medical treatment, although this is very important, but of the burden these older people place on their loved ones.

The Rural Health Committee hopes to have regular meetings at least on a quarterly basis at convenient places in the State, and to make an effort whereby different groups of local people may present their problems and their ideas of methods to combat these problems. (See Reference Committee Recommendation and House of Delegates Action following Supplementary Report of Rural Health below).

Supplementary Report of Rural Health, No. B Clarkesville Lab School

ALBERT MORRIS, M.D., *Chairman*

Status of the Medical Technician Assistant Training Program at the Clarkesville Vocational School:

On Sunday, April 26, 1959, a meeting was held at the Academy of Medicine and attended by representatives of Georgia Chapter of Medical Technologists; Georgia State Department of Public Health; Medical Association of Georgia Investigation Committee; American Society of Clinical Pathologists; and officials of the Clarkesville Vocational School.

The purpose of the meeting was to determine the exact feeling of the proposed training for medical technician assistants and to make definite plans for starting the program at the Clarkesville School.

Since definite cooperation from members of the ASCP and the Society of Medical Technologists could not be had, and in fact, definite opposition was expressed to the program; it was decided that the question and problem be referred back to the Rural Health Committee.

Consequently, it is recommended that the Medical Association of Georgia give tentative approval to the program for another year. This will be enough time so that the following can be determined: 1) make a survey to determine whether there is a need for such an individual in the practice of medicine in the state, and 2) form a liaison with the officials of the School, the medical technologists, and the Rural Health Committee, to determine just how extensive a curriculum will be required for such students. It is felt that this courtesy should be given to the officials of the school at Clarkesville since they have already spent approximately \$15,000 in preparation for the program. (The School was given approval by MAG and have acted in good faith.) Now these people are caught in the middle, so to speak. They are willing to aid the medical picture in the State and should not be subjected to the grievances of a group or groups within the framework of organized medical services.

REFERENCE COMMITTEE RECOMMENDATION — This Committee approves the report and the Supplementary Report of the Rural Health No. B: Clarkesville Lab School and recommends that tentative approval of the Clarkesville Lab School Program be continued for another year.

HOUSE OF DELEGATES ACTION — Adopted the report of the Rural Health Committee and the Supplementary Report of the Rural Health Committee No. B: Clarkesville Lab School as recommended by the Reference Committee on motion duly made and seconded.

Ministerial Liaison

NEEDHAM B. BATEMAN, M.D., *Chairman*

(1) Your Committee has, during the past year, concentrated on the following:

- (a) Acquainted the officers and members of each county medical society in Georgia with the aims and purposes of this committee.
- (b) Encouraged the county medical societies to set up their own County Ministerial Liaison Committees where they deemed it advisable.
- (c) Informed each minister in Georgia of the various denominations by a personal letter as to the existence, aims, and purpose of the Ministerial Liaison Committee of the Medical Association of Georgia.
- (d) Supplied speakers from the medical profession to lay groups when they have been requested.
- (e) Kept the office of the Medical Association of Georgia fully informed of our activities.

(2) The following letter was mailed to each officer of each county medical society in Georgia and to each minister in Georgia of the various churches and faiths:

"Dear Friend: The Medical Association of Georgia Ministerial Committee has developed certain objectives which require the sincere and wholehearted cooperation of doctors and ministers—and your cooperation is requested to achieve the following aims:

"(1) Create a better understanding between the ministerial and medical professions to bring about closer cooperation between individual members of the two groups.

"(2) To place the medical profession and the individual physician in closer contact with the clergy in the interest of the patient, his family, and friends—thereby letting the public know of the sincere desire of each doctor to serve and fulfill his duty to fellowmen.

"(3) To make each physician cognizant that ministers are dedicated similarly to duty and service to the patient, his family, and friends—and that this duty is fulfilled under somewhat the same arduous circumstances as that of the doctor.

"(4) To acquaint the members of the two professions with the many ways they can work together to great advantage in treating both the physically and mentally ill—and by working together administering to the *whole patient*.

"(5) To encourage ministers and their organizations to call on physicians to serve as speakers, members of panels, committees, etc., when the aid or opinion of one medically trained and experienced is desired.

"(6) To remind doctors of the willingness of the minister and his organization to work with the members and groups of the medical profession; of their understanding of the problems of the sick; and their readiness to join with doctors in solving common problems of both professions.

"These aims can only be accomplished by 'grass roots' cooperation. To that end the MAG Ministerial Liaison Committee recommends that each county medical society appoint a Ministerial Liaison Committee to serve the community. It is further recommended that each doctor serve as a committee-of-one to help in this undertaking.

"P.S.: The enclosed booklet, 'Near Life, Near Death,

Near God,' a reprint from the *AMA Journal*, April 13, 1957, is submitted for your information and file."

(3) With the above letter we also enclosed a booklet entitled "Near Life, Near Death, Near God," reprinted from the *Journal of the American Medical Association*, April 13, 1957; by Milton Golin, assistant to the editor, which has attracted national and worldwide attention.

We are greatly indebted to Christopher John McLoughlin, Secretary-Treasurer, and Mr. Milton Davis Krueger, Executive Secretary of the Medical Association of Georgia for their splendid suggestions, assistance, and cooperation during the past 12 months. Without their guidance and help, we could not have accomplished nearly so much.

(4) Lest you forget, the aims and functions of the Ministerial Liaison Committee are listed again and are as follows:

- (a) Create a better understanding between the ministerial and medical professions and to bring about closer cooperation between the two groups and their individual members.
- (b) To place the medical profession and the individual physician in a better light in the eyes of the clergy, the public at large, and of course the patient, his family, and friends by letting them see for themselves the sincere desire of the Men of Medicine to serve and fulfill their duty to their profession and their fellowmen.
- (c) To help our physicians realize that others, especially the ministers, are dedicated to duty and to service and that they have arduous and long hours often under adverse circumstances the same as the doctor; that they are often imposed upon by scheming and unscrupulous persons; and are frequently called on to work with the confused, the frustrated, the inadequate, the immature, the emotionally disturbed, the physically sick, the unloved, the unwanted, and the unfortunate the same as the doctor.
- (d) To acquaint the members of the two professions with the many ways they can work with each other to great advantage where individuals, families, communities, and peoples are concerned.
- (e) To point out to ministers and their organizations how easy it is to secure doctors as speakers, members of panels, committees, etc., when the help or opinion of one trained and experienced in medicine is desired.
- (f) To remind the doctors and his organizations of the willingness of the minister and his organizations to work with the members and groups of the medical profession; of their understanding of us and our common problems; and their readiness to join with us when invited, in any worthwhile meeting or undertaking.
- (g) To encourage physicians and physician organizations to work with the ministers, churches, civic groups, etc., for the benefit of the community and the public as a whole.
- (h) To encourage each county medical society to appoint a Ministerial Liaison Committee.

- (i) To tactfully suggest that our ministerial organizations on state, county, and city levels appoint Medical Liaison Committees to work along the lines of this committee from their end of the row.
- (j) To strive to keep all of this activity on the local level; that is, if a county ministerial group or church asks for a speaker or representative from the medical profession that this request be filled through the local county ministerial committee who calls on a local physician to fulfill this assignment. A local physician can do a better job in such cases and of course will be much more appreciated than some one from afar just there for the occasion.
- (k) To accept our duties as they come, giving of our time, strength, ability, and resources as they require.
- (l) To be careful not to trespass on the territory of any other Medical Association of Georgia group or committee and also being sure not to accept any duty that could more properly be handled by the officials or other committees of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION — This Committee approves the report of the Ministerial Liaison Committee and commends them for the great amount of work done during the year.

HOUSE OF DELEGATES ACTION — Adopted the report of the Ministerial Liaison Committee as recommended by the Reference Committee on motion duly made and seconded.

VFW Liaison Committee

W. BRUCE SCHAEFER, M.D., *Chairman*

The V. F. W. Liaison Committee has had only a minimum of meetings this past year, but we feel that the relations between the V. F. W. and the doctors over the states has been very good, and I wish to commend Charlie Andrews, the councilor of the Ninth District from Canton, Georgia, on the excellent work that he personally has done in bringing their relations about.

REFERENCE COMMITTEE RECOMMENDATION — This Committee approves the report of the Veterans of Foreign Wars Liaison Committee.

HOUSE OF DELEGATES ACTION — Adopted the report of the Veterans of Foreign Wars Liaison Committee as recommended by the Reference Committee on motion duly made and seconded.

Legislation

J. FRANK WALKER, M.D., *Chairman*

Your committee organized early this year at a meeting on June 11 in Atlanta. Plans for the year were made and matters referred by the House of Delegates were discussed. National legislative problems were also outlined.

In July, the Committee assisted the Medicare Review Board in a trip to Washington by contacting Senator Russell in Washington.

The district dinners planned in the Fall were not carried out to the extent we had hoped, but Albert Deal of Statesboro is to be commended for the fine work he has been doing in the First District. His an-

nual dinner of legislators and doctors was held again this year with much success.

At the end of the state legislative session, a dinner for the House Hygiene and Sanitation Committee was sponsored at the Piedmont Driving Club in Atlanta jointly with the Georgia Dental Association.

A trip to Washington to meet with Georgia's congressional delegation was to be accomplished on April 16. This has been worked out by Dr. Allen and is something we have been planning for a long time. It will be an informal affair including luncheon with our congressmen and senators.

State Legislation: The 1959 session of the Georgia General Assembly was as active a session as any in recent years. The Association was called upon to combat the annual Osteopath Bill which would have permitted D. O.'s to practice medicine and surgery in an unlimited way. The bill was overwhelmingly defeated in committee. It is hoped this problem can be worked out to assure the public of adequate protection and high standards of medical licensure.

Postponed until January, 1960 was the Insurance Code Revision Bill which would have made drastic changes in the present Blue Cross and Blue Shield enabling acts. MAG worked closely with a number of other health groups in the state to oppose the sections of this bill concerning the Blue Plans. The revision provided that "any person licensed to practice the healing arts upon human beings" may participate in non-profit plans. A similar bill in the Senate would have legislated Podiatrists into Georgia Blue Shield plans.

There were other matters of medical and health interest that were brought up in the legislature. The Committee would like to remind all members that this can be expected to happen each year and every effort should be made to maintain close liaison with our lawmakers.

National Legislation: The Forand Bill (H.R. 4700) was reintroduced in Congress and this will be the main concern in Washington during 1959-1960. Your Committee, as previously mentioned, has made a trip to Washington to maintain liaison with our Congressmen. We have met with AMA staff members and kept in touch with the AMA offices in Washington and Chicago in regard to this important legislation.

The Keogh-Simpson Bill, providing tax deferment for retirement savings by self-employed individuals, has passed the House and will be considered soon by the Senate Finance Committee. Senator Herman Talmadge is a member of this Committee.

There are too many physicians who worked hard on our overall legislative program during the year to mention them here by name. The Committee wishes to thank all of you for the fine support without which we could not function. Mr. John Kiser's relationship to the continued success of the committee is well known. Our key-man system, functioning at the grass roots is our most effective weapon in legislative activities and it must be maintained at its present high caliber.

REFERENCE COMMITTEE RECOMMENDATION — This Committee approves the report of the Legislation Committee and commends them for their excellent work during this year.

HOUSE OF DELEGATES ACTION — Adopted the report of the Legislation Committee as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 2
Keogh-Simpson Bill

FULTON COUNTY MEDICAL SOCIETY

WHEREAS, self-employed professional persons under present tax laws are unable to set aside retirement funds with the same advantage of employed persons, and

WHEREAS, the Keogh-Simpson Bill (H.R. 10) provides a just and fair solution to this problem by permitting physicians and other self-employed persons to set aside up to \$2,500 annually for the establishment of retirement plans, and

WHEREAS, this legislation has been endorsed by many professional associations including the American Medical Association, the American Bar Association, and the American Dental Association and has been twice approved by vote of the House of Representatives of the U. S. Congress,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia unanimously endorses the Keogh-Simpson Bill (H.R. 10),

AND BE IT FURTHER RESOLVED THAT both Senator Russell and Senator Talmadge be notified of this action of the MAG House of Delegates.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends the approval of Resolution No. 2: Keogh-Simpson Bill with an amendment that a copy of the Resolution be sent to all Georgia members of Congress.

HOUSE OF DELEGATES ACTION — Adopted Resolution No. 2: Keogh-Simpson Bill as amended by the Reference Committee on motion duly made and seconded.

Resolution No. 8
Tax Exempt Status

FULTON COUNTY MEDICAL SOCIETY

WHEREAS, the Fulton County Medical Society delegation is concerned about certain tax status questions, and

WHEREAS, medical societies operate for the purpose of promoting the science and art of medicine and the betterment of public health,

NOW THEREFORE BE IT RESOLVED, that the Committee on Legislation of the Medical Association of Georgia be requested to consider such legislation as stated herein, which would clearly define a medical society and its properties within a non-profit and tax exempt status:

"An Act to amend an 'Act to carry into effect Paragraph IV of Section I of Article VII of the Constitution of this State, in reference to the exemption from taxation of certain property therein described,' approved January 31, 1946 (Georgia Laws 1946, pages 12-13), as amended March 27, 1947 (Georgia Laws 1947, pages 1183-1186 inclusive), by including therein non-profit professional societies, whether incorporated or unincorporated, whose purposes are to promote and advance the study and practice of such profession and for other purposes.

"BE IT ENACTED by the General Assembly of the State of Georgia, and it is hereby enacted by authority of the same:

Section 1. That subparagraph (a) of Section I of

an Act approved January 31, 1946, relating to property exempt from taxation (Georgia Laws 1946, pages 12-13) as amended March 27, 1947 (Georgia Laws 1947, pages 1183-1186) be, and the same is hereby, amended by adding after the word "charity" occurring in the second line of said subparagraph, the words "non-profit professional societies, whether incorporated or unincorporated, whose purposes are to promote and advance the study and practice of such profession," so that subparagraph (a) of Section I said Act as amended shall read as follows:

(a) All public property; places of religious worship or burial; all institutions of purely public charity; non-profit professional societies, whether incorporated or unincorporated, whose purposes are to promote and advance the study and practice of such profession; hospitals not operated for the purpose of private or corporate profit and income; all intangible personal property owned by or irrevocable held in trust for the exclusive benefit of, religious, educational and charitable institutions, no part of the net profit from the operation of which can inure to the benefit of any private person; all buildings erected for and used as a college, non-profit hospitals, incorporated academy or other seminary of learning, and also all funds or property held or used as endowment by such colleges; non-profit hospitals, incorporated academies or seminaries of learning, providing the same is not invested in real estate; and provided, further, that said exemptions shall only apply to such colleges, non-profit hospitals, incorporated academies or other seminaries of learning as are open to the general public; provided further, that all endowments to institutions established for white people, shall be limited to white people, and all endowments to institutions established for colored people, shall be limited to colored people; the real and personal estate of any public library, and that of any other literary association, used by or connected with such library; all books and philosophical apparatus and all paintings and statuary of any company or association, kept in a public hall and not held as merchandise or for purposes of sale or gain; provided the property so exempted be not used for the purpose of private or corporate profit and income, distributable to shareholders in corporations owning such property or to other owners of such property, and any income from such property is used exclusively for religious, educational, and charitable purposes, or for either one or more of such purposes and for the purpose of maintaining and operating such institutions; this exemption shall not apply to real estate or buildings other than those used for the operation of such institutions and which is rented, leased or otherwise used for the primary purposes of securing an income thereon; and also provided that such donations or property shall not be predicated upon an agreement, contract or otherwise that the donor or donors shall receive or retain any part of the net or gross income of the property; farm products, including baled cotton grown in this State and remaining in the hands of the producer, but not longer than for the next year after their production.

Section II. All laws and parts of laws in conflict with this Act are hereby repealed."

REFERENCE COMMITTEE RECOMMENDATION — This Committee approves Resolution No. 8: Tax-Exempt Status.

HOUSE OF DELEGATES ACTION — Adopted Resolution No. 8: Tax Exempt Status as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 4 Positive Medical Legislation

SPALDING COUNTY MEDICAL SOCIETY

WHEREAS, the Medical Profession is constantly placed in the defensive position in fighting legislation in the national and the state legislative bodies, and

WHEREAS, this has created a general animosity toward the Medical Profession as a whole,

NOW THEREFORE BE IT RESOLVED that the delegates to the M.A.G. and A.M.A. be instructed to institute positive medical legislation or legislation related to the practice of medicine in both the state and the national legislative bodies and thereby place the M.A.G. and the A.M.A. in an offensive rather than a defensive position, and

BE IT FURTHER RESOLVED, that the A.M.A. and M.A.G. be duly noted of the action of this House of Delegates in order that the proper committees within the structure of the A.M.A. and the M.A.G. can start immediately with recommendations to friendly legislators regarding legislation which is directly or indirectly related to practice of medicine.

REFERENCE COMMITTEE RECOMMENDATION — This Committee disapproves Resolution No. 4 because the purpose of the Resolution is already being carried out by the present Committee on Legislation.

HOUSE OF DELEGATES ACTION — Adopted the recommendation of the Reference Committee in disapproving Resolution No. 4: Positive Medical Legislation.

Resolution No. 9 Non Licensed Practitioners

FLINT MEDICAL SOCIETY

WHEREAS, the laws of this state do not effectively prevent those who are not licensed to practice medicine and surgery from doing so, and

WHEREAS, Naturopaths, Chiropractors, and others have in the past been able to dispense medicines, including antibiotics and all other restricted drugs (except narcotics), and set fractures, do minor surgery, and deliver babies, which forms of surgery are by law supposed to be performed only by or under the supervision of Medical Doctors, and

WHEREAS, the crime of practicing medicine without a license is only punished as a misdemeanor,

NOW THEREFORE BE IT RESOLVED, that the Legislature be asked to prescribe more stringent punishment in order to prevent the continuation of such practices after trial has already been completed, and sentence passed. Proper protection of the public requires effective prevention of such practices, and if the crime should be reclassified as a felony, then this should be done. Suggested minimum to control these abuses is: two years imprisonment, and/or \$5,000 fine.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends the amendment of Resolution No. 9 on the advice of legal counsel and the Chairman of the Committee on Legislation, the amendment to read:

"NOW THEREFORE BE IT RESOLVED, that the House of Delegates urge the members of the Medical Association of Georgia to apprehend violators and to work with law enforcement officers in enforcing existing laws. Also to report violations to the Medical Association of Georgia Headquarters Office."

HOUSE OF DELEGATES ACTION — Speaker Goodwin recognized Virgil Williams, Fourth District Councilor who moved to delete the wording of the amendment to strike the words "apprehend violators and to" so that the Reference Committee amendment would read:

"NOW THEREFORE BE IT RESOLVED, that the House of Delegates urge the members of the Medical Association of Georgia to work with law enforcement officers in enforcing existing laws. Also to report violations to the Medical Association of Georgia Headquarters Office." The Williams motion was duly seconded and approved. The House of Delegates then adopted the Williams motion amendment to the Reference Committee amendment of Resolution No. 9: Non Licensed Practitioners.

Resolution No. 10 Sterilization

FLINT COUNTY MEDICAL SOCIETY

WHEREAS, there is no specific legislation in this state enabling voluntary sterilization, unless for definite medical indications, and

WHEREAS, there is no provision for sterilization of mental defectives, unless confined to state penal or mental institutions,

NOW THEREFORE BE IT RESOLVED, that the State Legislature be urged once again to enact such enabling legislation, with suggested provisions as follows:

(1) Any man who signs his consent to sterilization upon himself may not recover damages for the results of said operation from the surgeon, nor may his wife, or any future wife recover such damages.

(2) Elective sterilization of post-partum women may be performed without danger to the surgeon, provided the woman and her husband sign consent before witnesses. The number of successful pregnancies shall have no bearing on the liability of the surgeon.

(3) Any child whose Stanford-Benet I.Q. is shown to be below 51 by tests performed by the Dept. of Education, should have the tests repeated between the ages of 12 and 13, and if similar low scores are obtained, the child should be offered the opportunity to be sterilized, before the occurrence of, or following the delivery of an illegitimate pregnancy, such sterilization to be performed only with parental consent and the concurrence of two physicians other than the surgeon. A child who leaves school before being tested should have the opportunity of being tested at a State Mental Hygiene Clinic in order to qualify for elective sterilization.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends the disapproval of this Resolution.

HOUSE OF DELEGATES ACTION — Adopted the recommendation of the Reference Committee in disapproving Resolution No. 10: Sterilization on motion duly made and seconded.

Resolution No. 14 MD License Plates

CARROLL-DOUGLAS-HARALSON MEDICAL SOCIETY

WHEREAS, many physicians need proper identifica-

tion for their automobiles when making night calls and in emergencies, and

WHEREAS, a number of other states have enacted laws to provide for MD license plates,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates requests the Council and Committee on Legislation to consider the possibility of sponsoring legislation in the Georgia General Assembly so that all licensed MD's in the state will be furnished with license plates with "M.D." imprinted on the plate.

REFERENCE COMMITTEE RECOMMENDATION — This Committee recommends disapproval of the Resolution.

HOUSE OF DELEGATES ACTION — Adopted the recommendation of the Reference Committee in disapproving Resolution No. 14: MD License Plates on motion duly made and seconded.

Resolution No. 17 Board of Medical Examiners

J. H. ROBINSON, *Sumter County*

RESOLVED, that the Medical Association of Georgia request the Governor of the State of Georgia to select members of the Board of Examiners from nominees submitted by the district medical societies.

REFERENCE COMMITTEE RECOMMENDATION — This Committee amended Resolution No. 17 to read as follows:

"RESOLVED, that the Medical Association of Georgia request the Governor of the State of Georgia to make future appointments to the Board of Medical Examiners from a list of physicians submitted by the Council of the Medical Association of Georgia."

HOUSE OF DELEGATES ACTION — Adopted Resolution No. 17: Board of Medical Examiners as amended by the Reference Committee on motion duly made and seconded.

It was moved by Chairman of Reference Committee No. 5, Major Fowler, and duly seconded that the Report of Reference Committee No. 5 as amended be adopted as a whole and it was so ordered.

Unfinished Business

Speaker Goodwin called for unfinished business and none was introduced.

New Business

Speaker Goodwin recognized Vice-Speaker Fred Simonton, who related, for information only, certain data about the forthcoming "White House Conference on Health Care of the Aging," to be held early in 1960. He stated that the Governor of the State of Georgia will

appoint a committee representing the state and gave further information on the activity proposed at this conference.

Speaker Goodwin then called as the next order of business for the election by the House of Delegates of a Speaker and Vice-Speaker; the present terms of office having expired with this session. Speaker Goodwin read the Constitution and Bylaws, Chapter III, Section 6 as follows: "Election of Speaker and Vice-Speaker (every third year at Second Session of the House of Delegates during the Annual Session; their terms of office to begin with the adjournment of the House of Delegates; provided a Speaker and a Vice-Speaker be elected as the next order of business after the adoption of these Bylaws); .."

Speaker Goodwin turned the gavel of the House over to President Howard who then called for nominations for the office of Speaker of the House of Delegates. A. J. Waters, Richmond County, nominated Thomas W. Goodwin of Augusta and this nomination was seconded by Joseph B. Mercer, Glynn County, and others. On motion duly made and seconded it was voted that nominations be closed and President Howard then ruled there being no other nominations for the office of Speaker of the House that Thomas W. Goodwin, Augusta, was unanimously elected Speaker of the House of Delegates.

President Howard then called for nominations for the office of Vice-Speaker of the House of Delegates. President Howard recognized David R. Thomas, Richmond County, who nominated Fred Simonton, Chickamauga, as Vice-Speaker of the House and the nomination being duly seconded, Dr. Howard called for other nominations. On motion duly made and seconded it was moved that the nominations be closed and President Howard then ruled that there being no other nominations for the office of Vice-Speaker of the House that Fred Simonton of Chickamauga was unanimously elected Vice-Speaker of the House.

President Howard returned the gavel to Speaker of the House of Delegates Goodwin who called for further business and there being none on motion duly made and seconded it was moved that the meeting be adjourned.

The Second Session of the House of Delegates of the Medical Association of Georgia held in conjunction with the *105th Annual Session of the Association was adjourned at 11:05 A.M.

**Be Sure to Check August Issue
for the Complete Printing of
the Constitution and Bylaws of
the Medical Association of Georgia**

GENERAL BUSINESS SESSION

***105th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA**

MONDAY, MAY 18, 1959

THE FIRST GENERAL BUSINESS SESSION of the *105th Annual Session of the Medical Association of Georgia was called to order by President Lee Howard, Sr., Savannah, at 11:15 A.M. in the Crystal Room, Bon Air Hotel, Augusta.

President Lee Howard Sr. called on Charles Richardson, Sr. of Macon who introduced Dr. Louis M. Orr, President-Elect of the AMA, Orlando, Florida.

Dr. Orr presented an address titled "Time for Medicine's Re-Entry."

On completion of Dr. Orr's talk, President Howard turned the gavel over to First Vice-President George Alexander. Dr. Alexander then introduced President Lee Howard, Sr., who addressed the membership on the subject "Highlights of Medical Association of Georgia Achievements During 1958-59."

Upon completion of the President's speech, Lee Howard again assumed the duties of Presiding Officer.

President Howard appointed a Tellers Committee of William Harbin, Rome, Chairman; Eustace A. Allen, Atlanta; and T. A. Peterson, Savannah. Secretary-Treasurer Chris J. McLoughlin clarified the voting hours to begin immediately following the nominations at this Session and to close at 5:00 P.M., Tuesday afternoon, May 19, at the end of the last scientific session.

President Howard then called for nominations from the floor for Association officers and the nominations were made as follows:

Nominations

Association officers and nominations were made as follows:

President-Elect—Milford B. Hatcher, Macon: nominated by W. A. Wilkes, Augusta; and seconded by Fred Simonton, Chickamauga; Sam Patton, Macon; T. A. Peterson, Savannah; Roy Gibson, Columbus; Hilt Hammett, LaGrange; William Harbin, Rome; and John Robinson, Americus.

President-Elect—Jack Norris, Atlanta: nominated by W. A. Sellman, Atlanta; seconded by Major Fowler, Atlanta; C. L. Ayers, Toccoa; R. Hugh Wood, Atlanta; C. F. Holton, Savan-

nah; Edgar Boling, Atlanta; Hugh Hailey, Atlanta; and T. L. Byrd, Atlanta.

First Vice-President—Corbett Thigpen, Augusta: nominated by Hoke Wammock, Augusta; seconded by David R. Thomas, Augusta.

Second Vice-President—W. P. Rhyne, Albany: nominated by W. G. Elliott Cuthbert; seconded by Rudolph Bell, Thomasville.

AMA Delegate (term beginning January 1, 1960)—J. W. Chambers, LaGrange: nominated by Hilt Hammett, LaGrange; seconded by W. G. Elliott, Cuthbert; Thomas Goodwin, Augusta; J. G. McDaniel, Atlanta; W. L. Pomeroy, Waycross; and Lee Howard, Savannah.

AMA Alternate Delegate (term beginning January 1, 1960)—George R. Dillinger, Thomasville; nominated by Rudolph Bell, Thomasville; seconded by John Elliott, Savannah; and Virgil Williams, Griffin.

President Howard then referred to Chapter IV, Section 2 of the MAG Constitution and Bylaws as follows: "Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its Secretary to the Secretary of the Association not less than 15 days before the Annual Session. If no nomination has been presented by a district society in this manner, nominations shall be made from the floor."

President Howard then read the nominations from district societies as received according to the Constitution and Bylaws as follows:

Fifth District Councilor—J. G. McDaniel, Atlanta.

Fifth District Vice-Councilor—Charles S. Jones, Atlanta.

Sixth District Councilor—George Alexander, Forsyth.

Sixth District Vice-Councilor—William Weaver, Macon.

Seventh District Councilor—Ralph Fowler, Marietta.

Seventh District Vice-Councilor—Ralph Johnson, Rome.

Eighth District Councilor—F. G. Eldridge, Valdosta.

Eighth District Vice-Councilor—James M. Hicks, Brunswick.

President Howard then read a communication from the Fourth District Medical Society which placed in nomination the name of Jack H. Powell, Jr., Newnan, as Vice-Councilor for the Fourth District to fill the unexpired term of office of George P. Kinnard, Newnan, whose death necessitated this nomination.

President Howard then stated that nomination to an office without opposition was tantamount to election and instructed the membership that the only contested office was that of President-Elect. There being no further business the First General Business Session of the *105th Annual Session of the Medical Association of Georgia was adjourned at 1:20 P.M.

GENERAL BUSINESS SESSION (Second Session)

*105th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

WEDNESDAY, MAY 20, 1959

THE SECOND GENERAL BUSINESS of the *105th Annual Session of the Medical Association of Georgia was called to order by President Lee Howard, Sr. at 11:50 A.M. in the Crystal Room, Bon Air Hotel, Augusta, Georgia.

President Howard announced that a compilation of the official attendance at the *105th Annual Session was as follows: MAG Member Physicians, 756; Non-MAG Member Physicians, 41; Association Guests (Residents, Interns, Medical Students), 269; and Exhibitors, 170, making a grand total of 1,236 registrants.

GP of the Year Award

President Lee Howard called on Fred Simonton to present the GP of the Year Award. Dr. Simonton presented the Association 1959 General Practitioner of the Year Award to J. C. Logan of Plains, Georgia.

Fifty Year Certificates

President-Elect Luther H. Wolff presented 50-Year Certificates and Pins to physicians who have practiced medicine for 50 years or more. These presentations were made to the following physicians: H. M. S. Adams, Atlanta; James C. Anderson, Macon; David P. Belcher, Pelham; Charles S. Floyd, Lindale; Clayborne A. Harris, The Rock; William W. Hillis, Sardis; George F. Klugh, Sanford, N. C.; Hal C. Miller, Atlanta; Henry H. Oliff, Register; Q. A. Mulkey, Millen; Emory R. Park, LaGrange; Stephen C. Redd, Atlanta; Charles H. Richardson, Sr., Macon; John L. Taylor, Franklin; Marcus L. Webb, Tifton; Lehman W. Williams, Savannah (deceased); and Gabe W. Willis, Ocilla.

Hardman Cup Award

President Lee Howard, Sr. called on Dr. W. Bruce Schaefer to present the Hardman Cup Award to Edgar R. Pund, Augusta. Dr. Schaefer presented this Award in behalf of Mr. Lamartine Hardman who sent his heartiest congratulations to Dr. Pund. Dr. Schaefer congratulated Dr. Pund in behalf of the Association in receiving this high honor and award.

Certificates of Appreciation

Chris J. McLoughlin, Association Secretary-Treasurer presented Certificates of Appreciation in behalf of the Association to the following physicians and contributors to the Association ideals: Mr. John A. Dunaway, Atlanta, General Counsel, 1948-1958; David R. Thomas, Jr., Augusta, Chairman, Insurance and Economics Committee; Edgar R. Pund, Augusta, Medical Educator; George R. Dillinger, Thomasville, Chairman of Council, 1957-1959; Charles S. Jones, former Chairman Medicare Review Board; Mrs. Luther Wolff, Columbus, President Woman's Auxiliary, 1958-59; W. Bruce Schaefer, Toccoa, MAG Councilor; D. Lloyd

Wood, Dalton, MAG Councilor; and Lee Howard, Sr., President, 1958-1959.

President's Key

President Howard recognized Secretary-Treasurer Chris J. McLoughlin who presented the President's Key to the outgoing President Lee Howard, Sr. for his service to the Association. Dr. McLoughlin also presented Dr. Howard with a bound copy of the *Journal of the Medical Association of Georgia* published during his term of office as President.

Scientific Awards

President Howard called on Ted F. Leigh, Chairman of the Association Scientific Awards Committee who made the following presentations:

First Place Award — "Central Nervous System Neoplasms" —

John T. Godwin, M.D., Robert Mabon, M.D., William E. Coles and Pyrrha Grodman, Atlanta.

Second Place Award — "Use of Spirometry in the Study of Pulmonary Disease" —

Lois T. Ellison, David P. Hall, M.D., and Robert G. Ellison, M.D., Augusta.

Third Place Award — "The Treatment of Cardiac Arrhythmias" —

Zeb Lee Burrell, Jr., M.D., and William C. Gittinger, Milledgeville.

Honorable Mention — "The Technic of Disc Removal and Interbody Fusion by the Anterior Approach" —

George W. Smith, M.D., Mrs. Frances DeRoller, B.A., Floyd Bliven, M.D., Marcelino Chavez, M.D., and Ernest Daniel, M.D., Augusta.

Honorable Mention — "Congenital Chorioretinitis in Schools for the Blind" —

John R. Fair, M.D., Augusta.

Honorable Mention — "Hospital Staphylococcal Infections — Epidemiology and Control" —

Andre J. Nahmias and John T. Godwin, M.D., Atlanta.

Election Results

President Howard called on T. A. Peterson, Tellers Committee, for the election results. Dr. Peterson announced that the contested office of President-Elect of the Medical Association of Georgia had been won by Milford B. Hatcher, Macon.

Installation of Officers

The next order of business was the installation of the 1959-60 officers which are as follows:

President—Luther H. Wolff, Columbus (1960)

President-Elect—Milford B. Hatcher, Macon (1960)

Immediate Past President—Lee Howard, Sr., Savannah (1960)

First Vice-President—Corbett Thigpen, Augusta (1960)

Second Vice-President—W. P. Rhyne, Albany (1960)

Speaker of the House—Thomas W. Goodwin, Augusta (1962)

Vice-Speaker of the House—Fred H. Simonton, Chickamauga (1962)

AMA Delegate (term beginning January 1, 1960)—

J. W. Chambers, LaGrange (December 30, 1961)

AMA Alternate Delegate (term beginning January 1, 1960)

George R. Dillinger, Thomasville (December 31, 1961)

Fourth District Vice-Councilor—James Powell, Newnan (1961)

Fifth District Councilor—J. G. McDaniel, Atlanta (1962)

Fifth District Vice-Councilor—Charles S. Jones, Atlanta (1962)

Sixth District Councilor—George L. Alexander, Forsyth (1962)

Sixth District Vice-Councilor—William Weaver, Macon (1962)

Seventh District Councilor—Ralph Fowler, Marietta (1962)

Seventh District Vice-Councilor—Ralph Johnson, Rome (1962)

Eighth District Councilor—F. G. Eldridge, Valdosta (1962)

Eighth District Vice-Councilor—James M. Hicks (1962)

President Lee Howard, Sr. then turned the gavel over to President Luther H. Wolff for the installation of these officers.

President Wolff delivered his Inaugural Address.

Site of Future Annual Session

President Wolff then announced that the site for the 1960 Annual Session had been previously set for Columbus, Georgia. He called for invitations for the site of the 1961 Annual Session of the Medical Association of Georgia.

J. G. McDaniel, Atlanta, invited the Medical Association of Georgia in behalf of the Fulton County Medical Society to meet in Atlanta, Georgia in 1961. On motion duly made and seconded this invitation was graciously accepted.

President Wolff then entertained a motion for adjournment and on motion duly made and seconded the *105th Annual Session of the Medical Association of Georgia held at the Bon Air Hotel, Augusta, Georgia was adjourned at 12:45 P.M.

New Home of the Medical Association of Georgia located at 938 Peachtree Street, N.E., Atlanta, Georgia.





Reference Committee No. 1 in action.

CANDID CAMERA AT THE

AMA Delegate Henry H. Tift and President Luther H. Wolff.





Immediate Past President Lee Howard, Sr. (center), left, Hartwell Boyd and A. J. Kelley.



E. M. Lancaster, Shady Dale, votes for MAG officers.



Dr. Curtis Artz, guest speaker, addresses Surgery Section.

*105th ANNUAL SESSION

Mitton F. Bryant addresses Scientific Section.





Partial crowd that heard Dr. Paul Dudley White's address.



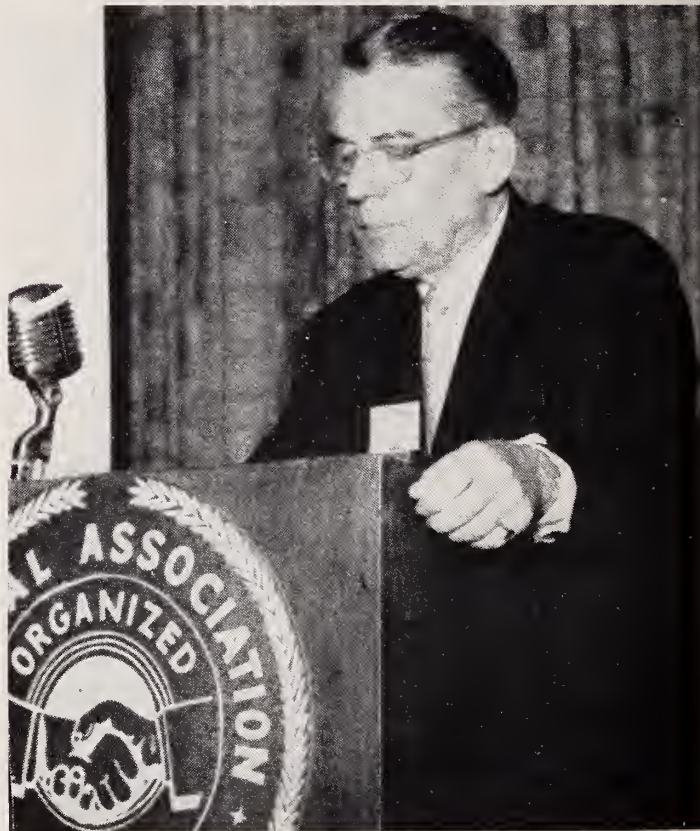
Dr. Paul Dudley White addresses the MAG; J. Willis Hurst, presiding.



Left to right, C. F. Hotton, C. H. Richardson, Louis M. Orr, and G. A. Alexander.



F. R. Mann, Sr. and A. P. Mulkey stop to chat about old times.
Delegates stop for refreshment.



Dr. Louis M. Orr, President of AMA speaking on "Medicine's Re-Entry."

W. Bruce Schaefer, Chairman of MAG Milledgeville Study Committee and Mr. H. C. Steed, Jr., Georgia Dept. of Public Health.





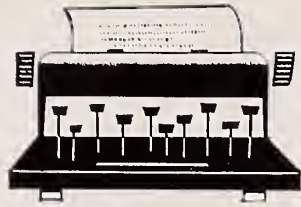
First prize exhibit in Scientific Section "Central Nervous System Neoplasms" by John T. Godwin, Robert Mabon, William E. Coles, and Pyrrha Grodman. Left, W. Bruce Schaefer and John T. Godwin view exhibit.

Milford B. Hatcher, new President-Elect of MAG.



Edgar Pund, 1959 winner of the Hardman Award.





editorials

Proceedings Issue

EACH YEAR the elected representatives of 71 component county medical societies in Georgia convene to deliberate and set forth policies which guide the Medical Association of Georgia. The actions of legislative body automatically become "the law" governing the MAG with its 2,800 member physicians.

The business of the Association is important and every Georgia doctor has a stake in the decisions of the MAG House of Delegates. So that all may know and understand these actions taken, the *Journal of the Medical Association of Georgia* each year devotes a special issue to the proceedings of the House.

These proceedings give an accurate account of all the affairs of medicine during the past year—and their resolution as recommended by the society delegates acting in behalf of their colleagues.

To be informed is to be intelligent. Each doctor should study and become cognizant of the official policies of the profession. The indexed record of actions of the MAG House of Delegates is printed in this issue of the *Journal* to serve as a guidepost and set of rules for the practice of medicine in Georgia. Read these proceedings for a better understanding of the work of your association.

Water Skiing Accidents

SUMMER IS WITH US again, and with it comes the popular sport of water skiing. This delightful outgrowth of the old Alpine art is in many respects safer than its parent sport, but as we survey the phenomenal increase in boating in general, it is well to consider the dangers of this new and growing sport. Its newness is one of the chief hazards, in-

viting as it does an increasing number of inexperienced enthusiasts.

The hazards of water skiing are in general related to the musculo-skeletal system. Those who are called upon to see injuries of this sort have seen their share of minor problems related to sprains, bruises, and simple fractures, caused by ill-advised, inten-

tional, and, at times, unintentional collisions with shores, docks, and other points of debarkation. One commonly seen problem is that of dislocations of the shoulder, which are particularly common in those so inclined. Major fractures are seen, but fortunately these are rare. Muscular avulsions, particularly caused by spills at high speed and failure to execute various "tricks" are occasionally seen.

Water sports in general often cause nasal pharyngeal complications. Face-forward falls bring on their share of sinus problems. It has been estimated by one in a position to know that approximately 100 ear drums are ruptured during the season as a result of water skiing in the Atlanta area alone.

The most serious problem faced by any one engaged in water activities is the possibility of drowning. In our increasingly crowded lakes where boat-

ing hazards increase directly as the number of boats rises, all skiers should be strongly urged to use such safety devices as a ski belt or other floatation apparatus. Collisions and accidents involving other boats greatly add to the hazard of being stunned from violent contact with the water. Increasing federal regulations should help in curtailing the leather jacket and hot rod set who are tending to abandon their motorcycles in the hot weather for the outboard motor. The water skier should remember that he, like the bicycle rider in dense traffic, is always the victim when a collision occurs.

The hazards associated with water skiing should not discourage proper participation in this enjoyable activity. Rather, it should encourage a sober and careful appraisal of the problem and its hazards.

James Funk, M.D.

Snake Bite

SNAKE BITE REMAINS an emergency albeit, a minor one. There are approximately two to three thousand snake venom poisonings in the United States each year.¹ The mortality rate is quite low. There were 71 deaths due to snake bite in the United States from 1950-1954 (one coral snake bite).⁴ Many reported cases of snake bite did not have proper therapy (failure to immobilize, delayed therapy, no antivenin) but recovered. This would further indicate that venom poisoning was rarely fatal. However, all devices for proper care should be employed to insure a good outcome. This means preventing morbidity, as well as mortality.

Ninety-eight per cent of bites are on the extremities. Most of them occur about twilight. The snakes are encountered around brush or wood piles, or the edge of a bank close to water. Rarely a face or body bite comes from a snake in a tree.

Many factors are concerned with the outcome of a snake bite. The bite is less serious if on the extremities. It is much less important if a scratch rather than the fangs embedded in the tissue. Venom deposited in fatty tissue is much less serious than in muscle tissue. A bite through clothing is often less

dangerous. Venom injected into a vein is extremely hazardous and usually followed by a fatal outcome. The size, age, and health of the victim, and the size and age of the snake are quite important. A large snake biting a small child is most dangerous.^{7d}

Snake venom diffuses rapidly through the tissues by enzymatic action.¹ It will even diffuse through refrigerated tissue and beyond the limitations of a tourniquet designed either for lymphatic or venous occlusion.² Early wide excision of tissue or amputation are of value as a surgical procedure.^{7f} Such steps are used in only the most demanding situations (multiple bites, large snakes, and small victims).

The venom of the pit vipers (rattler, moccasin, and copperhead) is predominantly proteolytic and cytolytic. There is a slight tendency to hemorrhage and some tendency to hemolysis. Fatal cases are encountered where circulatory collapse of obscure origin precedes death.^{5,7g,9} Neurotoxin is not found in the pit viper and therefore not important in this area of the world.

Chemical Injection at Site of Bite

All current authors are agreed that there are no

chemicals which applied or injected locally can counteract the venom.

Refrigeration (Cryotherapy)

This method of approach seems to alleviate pain and its use is confined to this property as far as treatment is concerned. Cooling will delay absorption of venom and in some instances may decrease local necrosis, but it will not lower mortality rate. If it is used it is discontinued as soon as antivenin is obtainable.^{2,3,4,5,6,8,9}

Tourniquet—Incision—Suction

Much controversy still exists over the value of these methods. Unless the Jackson¹¹ technique is used there is grave doubt if these methods are effective. This would be especially true if the victim was seen 30 or more minutes after the bite. Studies by Allen^{1,2} and Leopold et. al.³ and others^{6,7,8,7c,7d,7e} indicate that mechanical treatment has little place and may contribute to more extensive local necrosis without lowering the mortality rate. Some authors who are favorable to these methods simply state the value but do not have well documented evidence to support the claim. If tourniquet, incision, and suction are used, it should be accomplished within 20 to 30 minutes after the bite.^{7c,7d,7e} The tourniquet should be only tight enough to occlude lymphatic flow.

Immobilization

There is no need to give references concerning this approach to therapy. All writers are unanimous in the opinion that keeping the victim quiet is next to antivenin in importance. Such methods slow lymphatic and arterial circulation through the affected area. Splinting may aid in achieving this. The victim should not only be quiet but the affected area in the dependent position, if possible. Relief of pain (Demerol® or morphine if necessary) and sedation to relieve tension and fear (which greatly speeds up circulation) will be of great help. After emergency treatment, which includes antivenin (if available), the victim should be moved to a hospital and kept under observation for at least 24 hours. The blood should be typed immediately for immediate or future needs.

Antivenin

This is the mainstay in treatment.³ Ten to 50 cubic centimeters are given depending on the size of the snake, size of the victim, location, and type of bite. If seen early, 10 cubic centimeters may be given locally around the wound.^{7b} The remainder given proximal to the bite in the same extremity if possible, otherwise in the buttocks. Repeated doses are given

depending on the spread of swelling and general state of the victim. It is necessary to skin test for sensitivity prior to use of the antivenin since it contains horse serum. Hyaluronidase may be used with the antivenin.^{7c}

Antibiotics—Tetanus Toxoid—Tetanus Antitoxin

Because of the nature of the wound secondary infections are common. A broad spectrum antibiotic will be found useful in severe cases. After skin testing tetanus antitoxin should be given or a booster dose of tetanus toxoid. Cortisone and ACTH have not been beneficial. These two agents are not recommended.

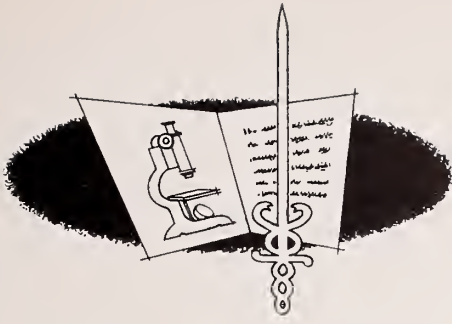
Circulatory Collapse

Saline solution, plasma or whole blood are great aids in combating shock and circulatory collapse.⁹ Methoxamine hydrochloride can be given intramuscularly or intravenously as an effective pressor agent without producing tachycardia, and therefore not increasing the circulation.¹⁰ Norepinephrine is a very reliable drug and may be used to sustain blood pressure and control shock. No alcohol should be used under any circumstances as a supportive measure.

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C. W. Strickler, Jr., M.D.



cancer page

BIOPSY: AN OFFICE PROCEDURE

Wm. J. Pendergrast, M.D. and Calvin B. Stewart, M.D., *Atlanta*

BIOPSY IS THE PRIMARY tool in tumor diagnosis. Clinical examinations, smears, and X-rays may lead one to suspect cancer, but the diagnosis may be questioned until a positive biopsy is obtained.

The American Cancer Society urges that every doctor's office become a cancer detection center. We strongly endorse this objective. A biopsy diagnosis reached in the office saves the patient's money and insurance for definitive treatment. This is important because many cancer patients have prolonged disability and some may never return to a gainful occupation.

Biopsy Techniques

Skin—Biopsy of all skin lesions is of great value in a teaching institution. We rarely biopsy the completely typical skin cancer prior to treatment in our private practice. Pigmented nevi should be totally excised. Melanoma should be excised with the patient in the hospital under general anesthesia and with pathologist available for frozen section. Radical excision should then be carried out.

Mouth and Throat—Biopsy of mucosal surfaces is readily accomplished with topical anesthesia because the ulcerating neoplasm is relatively insensitive. The tumor should not be traumatized by in-

jecting novocaine or by suture or cautery of the biopsy site.

Lymph Nodes—Abnormally enlarged lymph nodes should initiate the search for a primary tumor. A biopsy should be done only after repeated exhaustive examinations have failed to reveal a primary source. Needle aspiration biopsy offers distinct advantages over total excision. It is quick, easy, and fairly accurate and does not compromise the possibility of doing a curative lymph node dissection if cancer is found to be present.

Breast—The ulcerated nipple should be biopsied in the office and should be considered Paget's Disease until proven otherwise. Other breast tumors should be widely excised under general anesthesia with a pathologist present where available. Incisional biopsy as an office procedure has missed small deep seated cancers and is to be condemned. Needle aspiration of large breast cysts has proven to be a safe and satisfactory procedure and has eliminated the necessity for many surgical procedures.

Female Genitalia—The Papanicolaou Smear is a screening procedure most valuable for the completely normal patient. Biopsy as well as smears should be taken when a suspicious cervical lesion is found. The cervix is not sensitive and biopsy cause little

Approved by Professional Education Committee, Georgia Division, ACS.

discomfort. Schiller's Iodine Test is of value because it makes one examine the cervix closely and delineates abnormal areas. Cautery should be delayed until after the biopsy is reported. We are frequently faced with the problem of a questionable biopsy and a cervix already markedly altered by cautery.

Suction curettage of the endometrium in the office has almost totally replaced the hospital D & C in our practice. A trilene inhaler can be used to reduce pain when necessary. We use surgical D & C when the patient is very sensitive or when the suc-

tion biopsy specimen is not satisfactory. Suction curettage has proven to be as accurate as the surgical D & C in experienced hands. Wider use of this technique would relieve some of the patient load on our crowded hospitals.

Colon—Seventy per cent of colon carcinomas are within reach of the sigmoidoscope and suspicious areas can be easily biopsied. This should be done as part of every complete physical examination and will be especially valuable in people over age 40.

Let us practice what we preach. Make every doctor's office a cancer detection center. Buy a biopsy forceps and use it.

THE SCHAEFER COMMITTEE DID STATE AND PATIENTS AN INVALUABLE SERVICE

Governor Ernest Vandiver is taking steps to put into remedial action the report of the five doctors' committee headed by W. Bruce Schaefer which made a thorough study of conditions as they existed at Milledgeville State Hospital up until recently. And likely for the first time, the committee went about its work without incurring one dollar of expense to the state. The doctors paid their own way, and met all expenses of the investigation. The doctors and the Medical Association of Georgia have rendered the people of Georgia an invaluable service.

The report on what should be done has at the head of its important list of "musts," the administrative control of the mental institution, which has been transferred from the State Department of Welfare to the State Health Department.

The report recommended first of all, and quite properly, immediate action; 2nd, medium-range action; and 3rd, long-range action for improving the hospital.

The Schaefer committee worked diligently for weeks on their probe into affairs at the hospital. They were

not concerned with the manner of the business operation, but were interested in the medical care given the inmates.

Since the Schaefer committee began its work, there have been many resignations and changes at Milledgeville, and it is believed the changes will work for the betterment of conditions at the hospital. There will be no more operations or surgery performed by persons not authorized to do such work. There will be strict supervision of all that goes on in the medical profession within the hospital, and there will be greater benefits resulting to those who need hospitalization at Milledgeville.

Governor Vandiver is going to follow up the administrative procedures at the hospital to see that the fine program which was submitted in the long and inclusive report made by the doctors is carried out.

The doctors have laid the ground work for proper hospital administration which would be second to none, and it is hoped that a new day has dawned for those who must be patients at Milledgeville.

—Toccoa Record

. . . Soviet medicine is, to a large extent, dependent upon clinical diagnosis with a minimum of laboratory support.

. . . . The average Soviet physician does not enjoy the same status as a Soviet engineer.

. . . The Soviet pharmacopeia in practice is much more limited in quantity and quality than that in the United States as to range of available antibiotics and chemotherapeutic agents.



heart page

RUPTURE OF INTRACRANIAL ANEURYSMS

“BLOODY SPINAL FLUID.” Is it a traumatic spinal puncture or has the patient had a subarachnoid hemorrhage?

There are many causes of subarachnoid hemorrhage. The most common cause is a rupture of an aneurysm, congenital and saccular. This excludes the pediatric clientele.

The clinical findings are modified by the location and magnitude of hemorrhage. The tip-off is historically a “sudden unrelenting severe headache.” Usually, changes in sensorium and a stiff neck exist when first seen by the attending physician. Here a preliminary neurological evaluation (the base line) should be done. This should include study of the eyegrounds, vital signs, determination of focal or lateralizing neurological handicaps as may be exemplified by paralysis or weakness of extremities, face, or eye movements. If the status permits, skull and chest X-rays are next in order.

FINALLY, spinal fluid examination can be accomplished. This should be done as confirmation of clinical suspicions. Repeat punctures are unwarranted except as an aid to the consulting neurosurgeon in determining his plan of attack. The data obtained should be adequately recorded. It should include opening and closing pressures, the volume removed, appearance, cell count, protein, and leucic tests. Determination of the effect of jugular compression or having the patient to cough or strain is contraindicated. The latter should be used only in

Fleming L. Jolley, M.D., *Atlanta*

intraspinal problems. The preservation of a small volume of fluid in a test tube is a wonderful help for verification by its xanthochromia.

Initial treatment must be individualized according to the vital signs (respirations, level of consciousness, pulse and blood pressure). Adequate airway is most important. Tracheotomy should be carried out when there is any doubt. Transferring the patient is contraindicated during the bleeding phase.

Provided the patient has survived the initial “blow-out,” what next? In discussing the decision with the patient and/or the family there are certain facts. The initial hemorrhage is fatal in perhaps 30-35 per cent. An additional 30-35 per cent will have a second hemorrhage in the following two to four weeks. It appears safe to say that once the patient has bled from an aneurysm he will have future problems due to the same lesion.

Aneurysms can be demonstrated by arteriography and the procedure merits its performance in spite of occasional pitfalls. The use of local anesthesia has reduced certain hazardous features. Most victims of this problem are entitled to this procedure. Contraindications are senility, severe cardiovascular changes, and certain coexistent diseases. As to age

discretion there is no specific line, but perhaps a careful screening reduces the number after the fifth decade of life.

When should arteriography be performed? A more conservative and adequate approach has been on the sixth or seventh day after the bleeding episode as modified by the patient's general status. Present statistics do not indicate an improved survival or lessened morbidity rate by emergency surgery. This is in keeping with the thoughts that the immediate transfer of patients from one hospital to another in the first 48-72 hours is done so with added risks.

The individualized surgical management of the aneurysm, which may be single or multiple, is not

within the scope of this paper. No longer are multiple aneurysms necessarily contraindications to surgery. When one considers that the primary pathological defect of the vessel is within the internal elastic membrane of the artery, although rupture occurs from the aneurysmal tip, it would appear that the ultimate will be within the confines of a relative non-toxic enveloping material, plastic or otherwise, which can be applied so as to encase the entire pathological segment maintaining patency of the artery.

At the present time vessel or aneurysm occlusion is the method of choice. The desired is clipping of the aneurysmal neck at the parent vessel margin. Hopefully this maintains circulation. Less desirable efforts include segmental occlusion or carotid artery ligation.

THE MEDICAL EDUCATION SITUATION

Mr. THOMPSON of Texas. Mr. Speaker, I am interested in the medical education situation in the United States, particularly because the University of Texas Medical School is in Galveston, my hometown. With no little concern I have noted in recent months that the medical profession has been under attack in several areas of the press. As a result, I conferred with Dr. John Truslow, director of the Texas University Medical School, and then prepared seven questions dealing with medical education throughout the country, with a view to ascertaining whether sufficient qualified doctors are being produced to meet the needs of our rapidly growing population. I submitted these questions to Dr. F. J. L. Blasingame, of Wharton, Tex., an old friend and constituent of mine who went to Chicago a year ago to assume the responsibilities as executive vice president of the American Medical Association. I have complete confidence in Dr. Blasingame and his answers to the questions I submitted are very gratifying to me.

I was pleased to learn that since World War II there has been an increase in approved medical schools; that there is a substantial increase in medical students; and that, contrary to certain reports, the American Medical Association exercises no control over the number of students admitted to medical schools. There is much other valuable information in Dr. Blasingame's reply and I believe it will do much to eliminate certain misconceptions about the medical profession. Under leave

previously granted, I insert my letter to Dr. Blasingame and his reply:

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., March 9, 1959.

F. J. L. BLASINGAME, M.D.,
Executive Vice President,
American Medical Association,
Chicago, Ill.

DEAR DR. BLASINGAME: My attention has been called to a number of bills introduced in the 86th Congress affecting directly, or indirectly, the medical profession.

As a result, I wish to obtain certain information on the present supply of doctors in the United States and to ascertain as far as possible the prospects for an adequate supply of physicians to meet the needs of our growing population.

So I am calling on you, not only as executive vice president of the American Medical Association, but as my old friend and my loyal constituent to supply me with the information. On a separate sheet, I am submitting questions that occur to me in this connection. I know you can provide the facts; facts that should be made known to Congress before action is taken to consider legislation affecting the medical profession.

I am writing this after a conference with our mutual friend, Dr. John Truslow, head of the University of Texas medical branch in Galveston, who called on me today.

I will appreciate your answering these questions and

Extension of remarks of Hon. Clark W. Thompson of Texas in the House of Representatives, Thursday, April 23, 1959.

will further appreciate any other information you might give me that is relevant.

I want to say that I think you did a courageous thing in sacrificing your substantial private practice in Wharton to take over the direction of the AMA. I wish you great success.

Dr. Truslow joins me in sending you our best wishes.

Sincerely yours,

CLARK W. THOMPSON.

AMERICAN MEDICAL ASSOCIATION,

Chicago, Ill., April 16, 1959.

HON. CLARK W. THOMPSON,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN THOMPSON: Thank you for your recent letter and your interest in medical education.

It is indeed a pleasure to bring you an up-to-date report on the status of medical education in the United States. As you know, I am proud of the accomplishments of our medical schools and have great faith in their ability to train enough physicians to meet the needs of our growing population.

You asked seven important questions about the medical education picture. Let me answer them one by one.

First, has the number of physicians graduated from approved medical schools kept pace with the growth of the Nation's population? Over the long haul, the increase in medical graduates is much greater proportionately than is the increase in the population. From 1920 to 1958, the percentage of increase in medical graduates from approved schools was 125 per cent, compared with a 64 per cent increase in population. In the past 20 years, the percentage figures are fairly comparable: 32.1 per cent increase for medical graduates; 33.4 per cent increase for population.

The future, I believe, looks bright. Each year, for the past 11 years, the number of students enrolled in approved medical schools has increased. This boost in enrollment amounts to 29.6 per cent (from 22,739 to 29,473).

Your second question was whether medical schools seek to restrict the number of medical students. Two factors make it necessary for a school to establish an arbitrary top enrollment figure: facilities and budgetary funds available to operate the school. Each school faculty determines the number of students who can have a sound education with the faculty personnel and the facilities available to the school.

Medical education is a graduate educational experience following the completion of the regular college course, and because of the subject matter covered requires individual and small group instruction. To turn out well-trained, highly-qualified physicians the school requires a large faculty of skilled educators, plus sufficient teaching and research laboratories, hospital beds and clinical patients. The number of students that can be taught must be necessarily restricted to fit the facilities so that the emphasis can be on quality of the graduate rather than on the quantity of students.

Third, you asked: What is the ratio between applicants to medical schools and those accepted? The an-

swer is 1.97 (15,791 applicants for first year medical school to 8,030 places available). This ratio has remained about the same for the past five years.

Incidentally, a common confusion that arises in discussing applicants to student ratio is mistaking applications for people (applicants). Each person applies, on the average, to four medical schools. Thus, for the 1957-58 academic year, the 15,791 applicants filed a total of 60,946 applications.

Next, you asked if it is true that only students with an A college academic record are accepted into medical school. That has never been true. About one-sixth of the entering medical students for the whole country have A college records; about two-thirds have B records and about one-sixth have C records.

Your fifth question was: Is the number of medical schools increasing in the United States? In 1944, there were 77 approved medical schools, including eight 2-year schools from which students had to complete their final two years of medical education in any of the 69 4-year schools. In 1958, there were 85 approved medical schools. Eighty-one are 4-year schools; only four 2-year schools.

Two other schools are under development. As a step toward still further expansion of medical school facilities, the American Medical Association last year urged "institutions of higher education where medical education has not been undertaken in the past to give serious consideration to the development of opportunities in the field."

Sixth. Has the American Medical Association anything to do with the number of enrollments in medical schools? Enrollments are strictly determined by each individual medical school. Neither the universities nor their medical schools would permit an intrusion into their academic freedom by a national professional association.

Your final question asked whether I think it is necessary for Federal funds to be provided for medical schools. The medical profession welcomes one-time Federal grants for medical school construction and renovation as well as Federal grants for basic research. The profession has been opposed to continuing Federal aid for operating expenses because of the potentialities therein for Federal control.

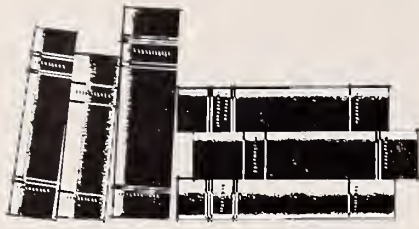
I should like to point out that the National Fund for Medical Education, which raises funds from industrial sources, and the American Medical Education Foundation, which raises funds from the medical profession, have made grants in excess of \$10 million to medical education over the past eight years.

I hope that information will aid you in analyzing bills introduced in the 86th Congress which pertain to the training of physicians. As further background, I am sending along a copy of the most recent annual report prepared by our council on medical education and hospitals, which was published in the *Journal of the American Medical Association*, November 15, 1958. It provides additional data that you might find useful.

I am happy that you wrote me after conferring with our mutual friend, Dr. John Truslow. If I can provide any additional information, please make your wishes known.

Sincerely yours,

F. J. L. BLASINGAME, M.D.



physician's bookshelf

BOOKS RECEIVED

Anning, S. T., T.D., M.A., M.D., (Cantab.), M.R.C.P., **LEG ULCERS**, Little, Brown and Company, Boston, Mass., 1954, 178 pp., \$4.00.

Blank, Harvey, M.D. and Rake, Geoffrey, M.D., B.S., **VIRAL AND RICKETTSIAL DISEASES**, Little, Brown and Company, Boston, Mass., 1955, 285 pp., \$8.50.

Hardy, James D., M.S., M.D., F.A.C.S., **TOTAL SURGICAL MANAGEMENT**, Grune & Stratton, Inc., New York, N Y., 1959, 292 pp., \$9.50.

McLaughlin, Harrison L., M.D., **TRAUMA**, W. B. Saunders Company, Philadelphia, Pa., 1959, 784 pp.

Dowling, Harry F., M.D., Sc.D. and Jones, Tom., B.F.A., **THAT THE PATIENT MAY KNOW**, W. B. Saunders Company, Philadelphia, Pa., 1959, 139 pp.

Hilleboe, Herman E., M.D. and Larimore, Granville W., M.D., **PREVENTIVE MEDICINE**, W. B. Saunders Company, Philadelphia, Pa., 1959, 731 pp.

Moyer, John H., M.D., **HYPERTENSION**, W. B. Saunders Company, Philadelphia, Pa., 1959, 790 pp.

Cecil, Russell L., M.D., Sc.D. and Loeb, Robert F., M.D., Sc. D., D. Hon. Causa., LL.D., **THE TEXTBOOK OF MEDICINE**, W. B. Saunders Company, Philadelphia, Pa., 1959, 1660 pp., index.

REVIEWS

Moseley, H Fred, M.A., M.D., M.Ch. (Oxon), F.A.C.S., F.R.C.S. (Eng.), F.R.C.S.(C), **TEXTBOOK OF SURGERY**, The C. V. Mosby Company, 1959, \$17.00, 1336 pp.

THIS THIRD EDITION published by The C. V. Mosby Company is well organized and contains all of the essential needs of a practicing surgeon today. In addition there is an excellent section on the evaluation of modern surgery beginning with Jonathan Hutchison and extending on up to our contemporary finely trained specialists. There are chapters on inflammation and repair, surgical bacteriology and chemotherapy with the modern application of antibiotics considered in detail, and several

of the most severe pathogens considered as single entities. These include the streptococcus, the staphylococcus, the clostridial organisms as well as mixed infections. In addition there is a new chapter on pediatric surgery written by Dr. Gordon M. Karn and Dr. Harvey E. Beardmore of the Montreal Children's Hospital which is quite representative of this specialty.

The section on surgery of the heart, great vessels, and lungs has been completely re-written, extended, and with the aid of Dr. F. Netter's magnificent illustrations this section is well worth while. There is an additional coverage of the ankle and foot to correspond with the excellent chapters on the hip and the knee with 21 additional color plates added here.

The bibliography at the end of each chapter including references to films, which are available concerning each of these particular sections, is excellent. The illustrations are the best of any surgical textbook which I have seen to date. Although I do not regard the book as complete as Christopher's Textbook of Surgery, it is very well done and certainly should prove useful by anyone practicing a surgical art.

Robert H. Vaughan, M.D.

Anning, S. T., T.D., M.A., M.D., (Cantab.), M.R.C.P., **LEG ULCERS, THEIR CAUSES AND TREATMENT**, Little, Brown and Company, 1954, \$4.00, 178 pp.

THIS SMALL VOLUME on a very common, but very abstruse clinical condition is well worth calling attention to, even at this late date. It renews one's faith in the value of clinical observation and perception, and causes one to appreciate the beauty of the English language. The historical interpolation and illustrations are exceptional. The careful reading of Chapter III, alone, will make this volume valuable to both the practitioner and the specialist.

Herbert S. Alden, M.D.

Arrington, George E., Jr., M.D., **A HISTORY OF OPHTHALMOLOGY**, M. D. Publications, New York, 1959, 174 pp., \$4.00.

FOR AN AGE in which the literature of medicine is becoming more esoteric, and ophthalmologists are being forced into the role of technical experts, there is a great

Acknowledgement of all books will be made in this column and this will be deemed by the Journal as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

need for books on the order of this one. There is a valuable appendix which lists the chronology of contributions and a directory of the current journals and societies in ophthalmology. However, the essential purpose is the presentation of the development of knowledge in the specialty, its evolution and relation to other medical and cultural concepts.

P. Thomas Manchester, Jr., M.D.

United States Department of Defense, SURGERY IN WORLD WAR II, NEUROSURGERY, VOL. I, Published by the Surgeon General, Department of the Army, U. S. Government Printing Office, Washington, D. C., 1959, 466 pp., \$5.00.

THIS IS A FASCINATING book for reading as well as for reference. It is a compilation of the experiences of many neurosurgeons exposed to a tremendous cross-section of craniocerebral injuries, recorded in a most instructive fashion. The use of multiple authors guarantees avoidance of rigidity of ideas, which very often infiltrates a single authored text.

On numerous occasions residents, interns, and students have asked if a book were available which could satisfactorily answer their questions regarding craniocerebral wounds. My answer has been that I knew of no single textbook which could cope with the manifold and recurring problems which confront one who sees this type of injury moderately frequently. This volume approaches that ideal as closely as any with which I have come in contact.

There is much to be learned from this book, not only by the novice but by one well versed, experienced, and trained in the management of head injuries. It is a welcome addition to the general surgeon's bookshelf as well as to the neurosurgical specialist and I recommend it unreservedly for all those who have even a modest interest in traumatic surgery.

Robert F. Mabon, M.D.

DePalma, Anthony F., M.D., THE MANAGEMENT OF FRACTURES AND DISLOCATIONS, W. B. Saunders Company, Philadelphia, Pa., 1959, 960 pp., 2 vols.

THIS ATLAS HAS BEEN produced in two volumes. Containing nearly 2,000 illustrations, an effort has been made to describe by picture management, 237 conditions related to skeletal injuries, fractures, and dislocations. Photographs were taken of the various steps of the management of a particular type of fracture or dislocation seen at the Jefferson Hospital Fracture Clinic in Philadelphia. The photographs in turn were translated into line drawings.

The atlas is quite comprehensive. In general, the author is versatile in his approach to the conservative

management of fractures. Usually the reader is given one or more methods of handling a particular injury. If operative reduction is necessary, the exposure is described in a satisfactory manner.

There are certain chapters which are particularly good. Chapters concerning the shoulder and the ankle are superior. There are criticisms which one should recognize. It contains 960 pages and is rather large and heavy. The paper is not of the best texture. It is, at times, repetitious as to treatment and to surgical approaches. Its price may discourage some.

This reviewer, however, in all fairness, feels that this atlas contains a wealth of information. If one follows the principles of management, as outlined for the various fractures and injuries covered, very few, if any, errors will be made. It will have its greatest usefulness as a guide for the student of trauma.

Wood Lovell, M.D.

Duncan, Garfield G., M.D., DISEASES OF METABOLISM, W. B. Saunders Company, Philadelphia, Pa., 1959, 1104 pp., \$18.50.

THE EDITOR OF THIS VOLUME, himself an outstanding clinician, has called upon many recognized authorities to present the latest views and concepts on the diagnosis and treatment of diseases of metabolism. Not only are carbohydrate, protein and fat metabolism discussed in detail, but also the metabolism of minerals. There are excellent and very complete chapters on water balance, vitamins, undernutrition and obesity, gout, porphyrin metabolism, spontaneous hypoglycemia, diseases of the thyroid and kidneys, and diabetes in its many and various forms. Each chapter has an abundance of figures, but there are few actual illustrations. The quality of the paper is excellent and the print is quite easily read. The book is not intended as a text for medical students or general practitioners but is an excellent reference work or text for the internist.

Chris J. McLoughlin, M.D.

Goodrich, Frederick W., Jr., M.D., MATERNITY, Prentice-Hall, Inc., Englewood Cliffs, N. J., 130 pp., \$1.75.

THIS NEW AND CONCISE book is another of the prenatal instructive books for expectant mothers and fathers. The chapter arrangement is well done and the instructions given are in keeping with current day obstetrical care. The author, quite rightly so, refers the final decision on controversial matters to the attending physician.

The one criticism that could be made of the book is that there are not enough diagrams and instructive pictures.

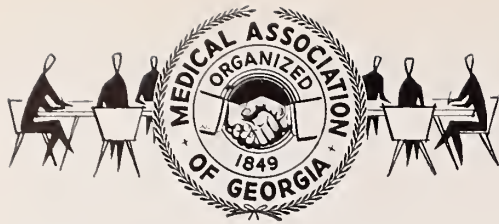
Joseph L. Girardeau, M.D.

VOLUNTARY HEALTH INSURANCE

About seven out of every ten U. S. families now have some form of protection under voluntary health insurance, Health Information Foundation reports. The proportion of insured families has increased almost 10 per cent in the last five years.

Voluntary health insurance coverage is increasing

faster among people 65 and over than among any other age group in the country. Forty-three per cent of the population 65 and older now has such insurance—an increase of almost 40 per cent in the last five years.



the association

ANNOUNCEMENTS

The American Urological Association offers an annual award of \$1,000 (first prize of \$500, second prize \$300, and third prize \$200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than ten years, and to hospital internes and residents doing research work in urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Palmer House, Chicago, Illinois, May 16-19, 1960.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1959.

A Sports Medicine Congress, one of the most significant conferences of its kind ever scheduled, will be held in conjunction with the Third Pan American Games, scheduled for Chicago next August 27 - September 7.

The Congress will meet on the Chicago campus of Northwestern University September 1-2, and will feature outstanding experts in the fields of athletic training, care of injuries, diet, cardiovascular effects of sports activity, and many other facets of the sports medicine field.

DEATHS

HENRY GRADY ESTES, 67, of Atlanta died June 6 after a short illness.

Born in Rex, Dr. Estes was graduated from the Atlanta College of Physicians and Surgeons, now Emory University Medical School. He practiced medicine in Atlanta for 46 years.

Dr. Estes was a member of Chi Rho Sigma fraternity, the Shrine, and a life member of the Atlanta

Athletic Club. He was a Mason and a member of the Peachtree Road Methodist Church.

He was a member of the Fulton County Medical Society, The Medical Association of Georgia, and the American Medical Association.

Survivors include his wife; two daughters, Mrs. George Vance and Mrs. Walter Cargill, Atlanta; three sisters, Mrs. D. R. Longino, Atlanta, Mrs. R. C. Cousins, Jonesboro, and Mrs. W. A. Ware, Tuscumbia, Ala.; a brother, Walter Estes, Rex; five grandchildren; and many nieces and nephews.

SAGE HARPER, 51, of Douglas died May 26 after an extensive illness.

He received his pre-med training at the University of Georgia, his M.D. degree from the Medical College of Georgia in 1933, and interned in Miami.

Dr. Harper began practicing medicine with his father in Wray, later opened his own office in Ambrose where he practiced until 1940 when he entered military service. Following the war he came to Douglas and began a new practice.

He was a former exalted ruler of the Douglas Lodge of Elks and for a time was a trustee of Aidmore Hospital in Atlanta. Dr. Harper was honored many times by the members of his profession, being president of the Georgia Academy of General Practitioners at the time of his death.

Survivors include his wife; one daughter, Merideth Harper; two sons, Mike and Kenneth Harper; and a devoted aunt, Miss Martha Brown.

ARMENIOUS C. HOBBS, JR. was killed in an automobile accident May 8. Dr. Hobbs was 39 at the time of the accident and lived in Columbus.

He was graduated from Hamilton High School, attended Emory University, was graduated from Pennsylvania State College of Optometry, and received his medical degree from the Medical College of Georgia. He did post-graduate work in ophthalmology at Thigpen-Cater Eye Hospital in Birmingham, a division of

the Medical College of Alabama. He served as a captain in the Army Medical Corps.

Dr. Hobbs was a member of the Societe Francaise d'Ophthalmologie, a diplomat of the American Academy of Ophthalmology an Otolaryngology, a member of the American Research in Ophthalmology, and the Georgia Eye, Ear, Nose, and Throat Association.

He was serving as president of the Columbus Philharmonic Guild at the time of his death. He also was secretary-treasurer of the Muscogee Medical Society and was an associate editor of *The Bulletin*, the society's official publication. He was a consultant on ophthalmology at Fort Benning and at Tuskegee (Ala.) Veterans Administration Hospital.

Dr. Hobbs had served on the board of directors of the Columbus Girls Club since its founding, was a member of the board of stewards at St. Paul Methodist Church, the Columbus Rotary Club, Executives Club, the Bachelors, and Columbus Country Club.

Survivors include his mother, Mrs. A. C. Hobbs, Sr. and a sister Mrs. Walter K. Johnson of Columbus.

O. W. KITCHENS of Byromville died June 1 in a hospital in Montezuma.

Dr. Kitchens had practiced medicine in Byromville for more than 40 years. He was a graduate of Atlanta Medical College, now a part of Emory University.

He was a member of Byromville Baptist Church, a Mason, and a Shriner. He was also a member of the Medical Association of Georgia and the American Medical Association.

Dr. Kitchens was vice chairman of the Dooly County Board of Commissioners.

Survivors include his wife; two sons, Dr. O. W. Kitchens, Jr., Byromville and Dr. M. C. Kitchens of Vienna; seven grandchildren; three sisters, Mrs. F. S. Thompson, Atlanta, Mrs. W. B. Griner, Orlando, Fla., and Mrs. B. O. Fry of Griffin.

L. FIELDING LANIER, 81, of Sylvania died at the Screven County Hospital, May 10, after a long illness.

Dr. Lanier was born in Milledgeville where his father was then practicing medicine. When a small lad his father moved to Sylvania. He graduated from the Sylvania High School in 1893 at the age of fifteen. He then attended Dalonega Military College. He graduated, with honor, from the Medical School of Georgia in 1910. He taught school several years during the time he was pursuing his medical degree.

Dr. Lanier studied medicine all of his life doing post-graduate work at Harvard and Columbia Universities. He received citations from both President Roosevelt and President Truman for his work in selective service. He was at one time president of the Screven County Medical Society, president of the Tri-County Medical Society, and president of the First District Medical Association.

Survivors include his wife; two sisters, Miss Clyde Lanier and Mrs. Alice Potter, Savannah; three nieces, Mrs. Darin Nash and Mrs. Alice Potter, Savannah, and Mrs. Roy Vinson, St. Petersburg, Fla.; and a number of great nieces and nephews.

WILLIAM EMORY LIPSCOMB of Cumming died April 26 at the Forsyth County Hospital following a short illness.

He was a graduate of the Atlanta College of Physicians and Surgeons, now a part of Emory University. He practiced medicine in Forsyth County for more than 50 years prior to his death.

Dr. Lipscomb was a Mason and active in church and civic affairs. Last year he was presented a 50-year membership pin from the Masonic Lodge. He was also a member of the American Medical Association, Southern Medical Association, and the Medical Association of Georgia.

HAROLD FRANKLIN SHIELDS, SR., 78, of Chickamauga died in the Hutcheson Memorial Hospital May 7.

Dr. Shields was born in Rock Springs, attended Rock Springs school, was graduated from Demorest College at Demorest, and received his medical degree from Emory Medical School in 1908.

He was a member of the North Georgia Foxhunters Association, Cookeville (Tenn.) Foxhunters Association, and the Fort Payne (Ala.) Foxhunters Association. He was a deacon of the First Baptist Church in Chickamauga, and was a member of Crawfish Springs Lodge of Masons.

Last year, shortly after his illness, The Medical Association of Georgia honored Dr. Shields for his "long and distinguished record" during 50 years of "service to his fellowman."

Survivors include his wife; five daughters, Mrs. Walter T. Fugate, Mrs. Theodore H. Wing, Mrs. Emory Shofner, Chickamauga, Mrs. James C. Wardlaw, Lafayette, Mrs. John Lyon, Fallbrook, Calif.; a son, Dr. H. F. Shields, Jr., Ringgold; three sisters, Mrs. Hattie Henderson, Chickamauga, Mrs. Robert Pursley, Chattanooga, Tenn., and Mrs. Ruth Mason, New Orleans, La.; a stepsister, Mrs. Vera Ransom, Chickamauga; a stepbrother, Hubert Hicks, Chickamauga; 12 grandchildren; and two great-grandchildren.

JOHN WESLEY SIMMONS of Brunswick died May 9 after a long illness at the age of 78.

A native Georgian, Dr. Simmons practiced medicine over 50 years. He was a charter member and past president of the Brunswick Rotary Club. He was a former president of the Board of Trade, now the Chamber of Commerce.

He was a life long member of the First Methodist Church and served on the board of stewards. A Mason, he recently received his 50-year pin from Ocean Lodge. He served as parliamentarian of the Medical Association of Georgia for 19 years.

Survivors include a daughter, Mrs. Donald Garrett, Atlanta; two sons, John W. Simmons, Jr., Brunswick and Dr. James O. Simmons, Woodbine; one sister, Mrs. Charles A. Smith; and one brother, James A. Simmons, both of Waynesboro; 11 grandchildren; and 11 great-grandchildren.

SOCIETIES

The Board of Trustees of the FULTON COUNTY MEDICAL SOCIETY has unanimously endorsed and approved the stepped-up activity of the Citizens Advisory Committee for Urban Renewal to rid the county of its slum areas.

Dr. R. L. Cook showed a film on "Mouth to Mouth Resuscitation" to the GEORGIA MEDICAL SOCIETY recently.

Dr. R. E. Semmes, professor of neurosurgery at the University of Tennessee's school of medicine, was guest speaker at the MUSCOGEE MEDICAL SOCIETY'S monthly meeting.

The MUSCOGEE MEDICAL SOCIETY has opened a campaign to urge persons under 40 years of age to take four polio shots as soon as possible.

The SPALDING COUNTY MEDICAL SOCIETY recently sponsored another polio clinic at the Cheatham Building of the First Baptist Church in Griffin.

The THOMAS-BROOKS MEDICAL SOCIETY held its quarterly meeting at the Archbold Memorial Hospital Out-Patient Department in Thomasville.

Members of the WARE COUNTY MEDICAL SOCIETY were entertained at the home of Dr. and Mrs. Joe Jackson for their monthly meeting.

The WAYNE COUNTY MEDICAL SOCIETY met recently in the staff room of the Wayne County Emergency Hospital.

The UPSON COUNTY MEDICAL SOCIETY and Auxiliary entertained at the FOURTH DISTRICT MEDICAL SOCIETY held recently at the Hotel Upson.

PERSONALS

First District

M. FERNAN-NUNEZ, Savannah, was the featured speaker at the annual convention banquet of the Georgia Society of Medical Technologists.

CHARLES G. GREEN, Waynesboro, has been presented a certificate of appreciation for ten years uncompensated service as medical advisor for the Local Board No. 17, Selective Service.

Announcement has been made that CHARLES T. BROWN, a native of Banks County and formerly a practicing physician at Guyton, has been named medical director of the Bulloch County Department of Public Health.

Second District

ABRAM GOLDSMITH, Albany, has been named a diplomate of the American Board of Obstetrics and Gynecology.

Third District

LEONARD T. MAHOLICK, Columbus, has assumed the office of president of the Georgia Psychiatric Association.

Fourth District

ALEX JONES, Griffin, was guest speaker at the dinner meeting of the ABC-ettes recently. His discussion topic was "License to Murder."

The family of J. H. GRUBBS, Molena, entertained at a dinner honoring him upon his reaching the three quarters of a century mark.

B. H. JENKINS, Newnan, has been credited with pioneering in the use of the drug to facilitate removal of cataracts without danger of tearing or damaging the eye.

Fifth District

JAMES THOROUGHMAN, chief of the surgical service at the Veterans Administration Hospital in Atlanta, spoke to the Gainesville Rotarians recently.

WILLIAM A. HOPKINS, Atlanta, addressed the annual meeting of the North Georgia Tuberculosis Association at the First Presbyterian Church in Gainesville recently.

RICHARD W. BLUMBERG, Atlanta, has given up his private medical practice to take over as full-time chairman of the department of pediatrics at the Emory University School of Medicine.

JOSEPH H. PATTERSON, Atlanta, has been named chief physician of the new Henrietta Egleston Hospital for Children, located across from Emory University Hospital.

T. O. VINSON, district director of public health for the DeKalb-Rockdale district, has been elected president-elect of the Georgia Public Health Association.

BERNARD S. LIPMAN, Atlanta, returned recently from Minneapolis where he was a guest lecturer for a post-graduate course in Electrocardiography given by the University of Minnesota Center for Continuation Study.

The featured speaker at the Savannah Claims Association annual banquet held at the DeSoto Hotel recently was JOHN R. LEWIS, JR., Atlanta.

Sixth District

A well-known Dublin physician, CHARLES A. HODGES, was honored recently on his 73rd birthday at a family dinner at his home.

Seventh District

VIRGINIA MALEY, Cartersville, recently received her Masters Degree from the University of North Carolina in Public Health Administration.

J. S. KALEY, Marietta, has opened an office for surgical practice in Marietta.

The fourth annual meeting of the Flint River Tuberculosis Association was held recently in Albany with JOHN H. GROSS, chief of White Service, Battey State Hospital, Rome, as the guest speaker.

Eighth District

No news submitted.

Ninth District

WARREN STRIBLING of Gainesville was among 125 doctors from 33 states and five foreign countries attending a one week post graduate course in internal medicine being held at Peter Bent Brigham Hospital and Harvard Medical School, Boston.

W. BRUCE SCHAEFER of Toccoa was the principal speaker at the graduation ceremonies for some 90 students of the Medical College of Georgia in Augusta.

Tenth District

Washington Kiwanians recently heard a talk by HARRY B. JOHNSTON, of Athens on the subject of the Economics of Medical Practice.

CORBETT H. THIGPEN of Augusta recently spoke at the Student American Medical Association convention. Dr. Thigpen also spoke at the regular meeting of the Tenth District Georgia State Nurses' Association on "Hypnotism."

COUNCIL MEETING

THE FINAL MEETING OF THE 1958-59 Council of the Medical Association of Georgia was called to order at 2:05 P.M., Saturday, May 16, 1959 at the Bon Air Hotel, Augusta, Georgia in the Augusta Room by Chairman George R. Dillinger, Thomasville.

Present, in addition to the Chairman were Lee Howard, Sr., Savannah, President; Luther Wolff, Columbus, Pres.-Elect; W. Bruce Schaefer, Toccoa, Immediate Past-President; George L. Alexander, Forsyth, First Vice-Pres.; Charles W. Hock, Augusta, Second Vice-Pres.; Chris J. McLoughlin, Atlanta, Secretary-Treasurer; Thomas W. Goodwin, Augusta, Speaker of the House; Fred Simonton, Chickamauga, Vice-Speaker; Charles T. Brown, Guyton, First District Councilor; W. G. Elliott, Cuthbert, Third District Councilor; Virgil B. Williams, Griffin, Fourth District Councilor; J. G. McDaniel, Atlanta, Fifth District Councilor; Henry H. Tift, Macon, Sixth District Councilor; D. Lloyd Wood, Dalton, Seventh District Councilor; Charles R. Andrews, Canton, Ninth District Councilor; Addison Simpson, Jr., Tenth District Councilor; T. A. Peterson, Savannah First District Vice-Councilor; Lewis P. Jordan, Columbus, Third District Vice-Councilor; Ralph W. Fowler, Marietta, Seventh District Vice-Councilor; Paul T. Scoggins, Commerce, Ninth District Vice-Councilor; David R. Thomas, Augusta, Tenth District Vice-Councilor; C. H. Richardson, Macon, AMA Delegate; J. W. Chambers, LaGrange, Alternate AMA Delegate; Wm. R. Dancy, Savannah, Alternate AMA Delegate; Also present were Edgar Woody, Jr., Atlanta, MAG Journal Editor; Public Service Commission Chairman, John P. Heard, Decatur; Mr. Frank Shackelford and Mr. John Moore, Atlanta, MAG General Counsel; AMA Field Representative Charles Johnson; Mr. Milton Krueger, Mr. John Kiser, and Mrs. Emily Grinalds of the Headquarters Office Staff.

After the invocation, the minutes of the Council meeting of March 7-8, 1959 were read by Mr. Krueger. Secretary McLoughlin objected to the word "unanimous" in regard to recommendations of the Constitution & By-Laws Committee. After discussion, it was voted (Goodwin-Wood) that the word "unanimous" be deleted, and the motion read "there was no dissenting vote."

Secretary McLoughlin questioned the improper wording of the "Council Committee on Reorganization" on page 2 of the Minutes of the Council of March 7-8. It was corrected to read "Council Committee on Committee Reorganization."

On motion (Elliott-Wood) it was voted that the minutes of the Council meeting of March 7-8, 1959 be approved as amended. This vote was unanimous.

Mr. Krueger read the minutes of the Executive Committee of Council meeting of March 9, 1959, and it was unanimously voted that these minutes stand approved as read.

Mr. Krueger read the minutes of the Executive Committee meeting of April 12, 1959. President-Elect Wolff stated that the Committee on Health Care of the Aging is not a part of the

Insurance & Economics Committee. This Committee should be appointed by Council. On motion (Wolff-Elliott) it was voted that the Committee on Health Care of the Aging is a Council Committee of MAG.

On motion (Wolff-Elliott) it was unanimously voted that the minutes of the Executive Committee of Council of April 12, 1959 be approved as corrected.

Secretary McLoughlin expressed appreciation for the flowers and telegram sent to him by the Council while he was ill.

SIMMONS MATTRESS COMPANY ADVERTISEMENT—Mr. Krueger read a letter from Mr. Hugh Butler, Vice President of Simmons Company in which Mr. Butler stated that he agreed the advertisement concerned was not in good taste for newspapers, but more appropriate for Medical Journals. He said it would not be used in Georgia newspapers again. He asked Mr. Krueger to report to MAG the Simmons Company's concern, and that they would be so governed in the future. On motion (Goodwin-Brown) it was voted to receive this report for information and that the subject be closed.

STUDENT AMERICAN MEDICAL ASSOCIATION CHICAGO MEETING—Mr. Krueger read a letter from Miss Edith DeZoost, Medical College of Georgia, requesting funds from MAG for attendance to the Annual SAMA Convention, May 1959, Chicago. On motion (Wood-Brown) it was voted that funds for transportation to the Chicago SAMA meeting be made available for this purpose from the Association's Contingent Fund.

PROPOSED MAG REHABILITATION COMMITTEE—Secretary McLoughlin read letters from Dr. F. James Funk and Dr. Robert L. Bennett stressing the importance of a MAG Rehabilitation Committee. He also stated that AMA recommends that every state should have a Committee on Rehabilitation. During discussion, it was brought out that Council must first approve the necessity for a Committee on Rehabilitation. On motion (Hock-Wood) it was voted that a Special Committee on Rehabilitation be formed.

PROPOSED MAG HEADQUARTERS OFFICE BLDG.—Secretary McLoughlin reported that a building suitable for a MAG Headquarters Office Building had been found by the Building Committee. It is the Gulf Life Insurance Company Building, 938 Peachtree Street, Atlanta, Georgia. The sales contract with the Gulf Life Insurance Company has been signed, and MAG has until June 15, 1959 for a final decision. The Building Committee recommends to the House of Delegates that this building be purchased. J. G. McDaniel introduced at this time the following resolution:

Supplementary Report of Council

No. C
(Referred to Ref. Comm. No. 3)
Subject: **MAG HEADQUARTERS OFFICE BUILDING**
By: George R. Dillinger, M.D.

On authority of Council action of Saturday, May 16, 1959, the Council approves and respectively recommends that the House of Delegates approve the following resolution:

WHEREAS, the 1958 MAG House of Delegates authorized Council to "proceed with the purchase or lease of suitable property for an MAG Headquarters Office Building," and

WHEREAS, a sales contract for the purchase of the Gulf Life Insurance Building at 938 Peachtree Street, Atlanta, has been executed by Council subject to the approval of the House of Delegates,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates adopt one of the following resolutions, the first of which Council unanimously recommends;

1. RESOLVED that the House of Delegates approves the sales contract prepared for the purchase of the Gulf Life Insurance Building at 938 Peachtree Street as a headquarters office building for the MAG.

2. RESOLVED that the House of Delegates defers action and hereby calls a special meeting of the House of Delegates in Atlanta, on a date before June 15, 1959 to be set by Council, for the purpose of inspecting the Gulf Life Building before taking action.

3. RESOLVED that the House of Delegates disapproves the sales contract prepared for the purchase of the Gulf Life Building.

General discussion ensued, and on motion (Elliott-Brown) it was voted that all three resolutions be submitted to the House of Delegates, with the notation that No. 1 is favored by the unanimous action of the Council.

INDUSTRIAL HEALTH COMMITTEE REPORT ON WORKMAN'S COMPENSATION—Ind. Health Comm. Chairman T. A. Peterson, Savannah, reported on a meeting with the State Board of Workman's Compensation. He recommended to the Council that members of this Board be invited to speak on certain problems of the Workman's Compensation before MAG Council. This

report was received for information. Chairman Dillinger suggested that Chairman Peterson work closely with General Counsel on this matter.

SOCIAL SECURITY RECOMMENDATIONS—President-Elect Wolff stated that he made the request that Council reconsider its action on Social Security in order that definite facts might be presented. He stated that he personally opposed inclusions of physicians under Social Security on philosophical grounds and as a matter of principle, and that the AMA has taken a similar stand. He read a report from the AMA. General discussion ensued. On motion (Wolff-Hock) it was voted that Council rescind the action taken concerning Social Security at the March 7-8 meeting. On motion (Goodwin-Elliott) it was unanimously voted that Council request the House of Delegates to ask each county medical society in this State to vote on this matter before the meeting of the House of Delegates in 1960, and to send their delegates to the meeting instructed on how to vote on this matter.

LEGISLATIVE COMMITTEE REPORT—Councilor Virgil Williams reported on MAG Legislative Comm. liaison meeting with Georgia Congressman, April 16, 1959, Washington, D. C. He said that a luncheon was held in the Speakers Dining Room, and that eight Representatives, Senator Talmadge, and Gov. Vandiver were present. Pres.-Elect Wolff, who also attended the luncheon, stated that this was one of the most fruitful gatherings that MAG has ever had, and that he hoped it would be a yearly event.

At this time, Vice-Chairman McDaniel took over the chair to preside in place of Chairman Dillinger.

MAG MILLEDGEVILLE STUDY COMMITTEE REPORT—Study Committee Chairman W. Bruce Schaefer reported on the two months of work by the members of this Committee. He complimented General Counsel John Moore for his able assistance to the Committee. He reported that the report was made at no cost to the tax-payer. General discussion ensued. Chairman Dillinger then read a proposed resolution to the House of Delegates as follows:

Supplementary Report of Council

No. A (Referred to Ref. Comm. No. 3)

Subject: **MILLEDGEVILLE COMMITTEE REPORT**

By: George R. Dillinger, M.D.

On authority of Council action of Saturday, May 16, 1959, the Council approves and respectfully recommends that the House of Delegates approve the following resolution;

WHEREAS, at the request of the Governor of the State of Georgia a committee from the Medical Association of Georgia appointed by the President and consisting of Drs. W. Bruce Schaefer, Toccoa, Chairman; John A. Bell, Jr., Dublin; Rives Chalmers, Atlanta; Corbett H. Thigpen, Augusta; and R. Hugh Wood, Atlanta, studied Milledgeville State Hospital and prepared a report for the Governor, and

WHEREAS, Governor Vandiver stated that after reading and studying the report, it was one of the finest, most authoritative and all-inclusive public documents he had ever read and that the members of the committee were due the highest praise for the workman-like job which they had done on that report without any cost whatsoever to the taxpayers of the State of Georgia, and

WHEREAS, it appears that a beginning has been made to improve the care and treatment of the mentally ill in the State of Georgia in part due to the efforts of the Medical Association of Georgia and the Committee appointed to study Milledgeville State Hospital,

NOW THEREFORE BE IT RESOLVED, that the Council and the House of Delegates of the Medical Association of Georgia hereby commends the members of this committee for their outstanding service to the mentally ill of this state,

AND BE IT FURTHER RESOLVED, that the Council and the House of Delegates of the Medical Association of Georgia approves in principle the report of the Committee appointed by the President of the Association at the request of the Governor to study Milledgeville State Hospital.

On motion (Dillinger-Howard) it was unanimously voted that

this resolution be approved, and referred to the House of Delegates.

Vice-Chairman McDaniel relinquished the chair to Chairman Dillinger.

QUARTERLY STATEMENT OF GENERAL COUNSEL—Secretary McLoughlin reported on the statement of services rendered by General Counsel for the first quarter of 1959 per agreement on annual retainer, and the statement for special services by General Counsel in serving the Milledgeville Study Committee. On motion duly made and seconded both of these items were approved for payment.

FINANCE COMMITTEE REPORT—Chairman McDaniel gave the Finance Committee Report. On motion duly made and seconded, it was voted to transfer \$5,000 from the Reserve Fund to the Contingent Fund. On motion (Schaefer-Elliott) it was voted that the report of the Finance Committee be approved as read.

HEADQUARTERS OFFICE REPORT—Mr. Krueger reported that the Headquarters Office Staff has been busy for the past month with matters concerning the Annual Session. He explained the Annual Session Program in detail. On motion duly made and seconded, this report was accepted for information.

UNFINISHED BUSINESS

HEALTH CARE OF THE AGING COMMITTEE—On motion (Wolff-McDaniel) it was voted that John Atwater, Atlanta, be appointed by MAG Council as Chairman of the Committee on Health Care of the Aging.

CLARKSVILLE LAB SCHOOL—Councilor D. Lloyd Wood reported for information of the Council that the Clarksville Lab. School is not in operation, and that the establishment of a school is meeting some opposition.

REPORT FROM CHMN. MED. CIVIL PREPAREDNESS CONCERNING MICRO-IDENTIFICATION PROGRAM IN EVENT OF ATTACK—Secretary McLoughlin reported that the Executive Committee has already acted on this matter. It was referred to Chm. Med. Civil Preparedness Edgar M. Dunstan, and he reported that the whole matter has been referred to the State Welfare Department, which has jurisdiction on this matter in the State of Georgia. On motion it was duly voted and seconded that MAG Council concur with Dr. Dunstan's actions in this matter.

NEW BUSINESS

Councilor F. G. Eldridge read a resolution from the Ware County Medical Society on HOSPITALIZATION FUND. This was accepted for the information of the Council.

Chairman Dillinger called on Field Representative Johnson of AMA for a few words.

Chairman of Public Relations Committee John P. Heard, Atlanta called Council's attention to an 18 page section of the Augusta Sunday paper, which contains medical news.

President Lee Howard, Sr., spoke of his deep appreciation of the work done by every member of the Council during the past year, and especially expressed his appreciation to Chairman Dillinger.

Chairman Dillinger thanked each Councilor for his cooperation, and expressed his great appreciation for the great amount of work done by all while he was Chairman of Council.

There being no further business, the meeting was adjourned at 5:20 P.M.

WEEKLY HEALTH COLUMN COMMITTEE MEETING

THE MEETING OF THE MAG Weekly Health Column Committee was called to order Wednesday, May 27, 1959 at 7:10 P.M. by Chairman H. C. Derrick, Jr., LaFayette, in the Academy of Medicine, Atlanta, Georgia.

Present, in addition to Chairman Derrick were August C. Yochem, Jr., Atlanta; C. J. Wyatt, Jr., Rome; Lamar F. Glass, Atlanta; Jule C. Neal, Jr., Macon; E. P. Inglis, Jr., Marietta; Edwina Davis and Mrs. Emily Grinalds of the Headquarters Office Staff.

Chairman Derrick read a letter from the Executive Committee of MAG Council requesting him to have an article on Radiologic Safety printed in the Weekly Health Column. He stated that J. Frank Walker, Atlanta, had consented to write this article, and requested Mrs. Grinalds to write him concerning this matter.

The following articles were approved for release:

A Heart Attack Doesn't Spell Doom
 Have Pilodunal Cysts Removed
 Epilepsy Is a Controllable Illness
 Help Prevent Emotional Illness
 Watch Your Weight
 Get Rid of Those Worms
 Acne Afflicts Many Teenagers
 Rectal Bleeding Doesn't Necessarily Mean Cancer
 Check Athlete's Foot
 Tuberculosis Is Still a Problem
 Warts Are Common Nuisances but Rarely Serious
 A Sprained Ankle Deserves Treatment
 Menopause Is a Normal Part of Life
 Removal of Womb Serious but Shouldn't Be Feared
 Needlessly
 Ear Infections Are Summer Hazard
 Angina Is a Symptom, Not a Disease

Chairman Derrick instructed Mrs. Grinalds to write Dr. J. A. Roberts, Marietta, Georgia and thank him for contributing an article on Pink Eye to the Weekly Health Column. He also instructed Mrs. Grinalds to write Dr. Ed. Johnson, Medical Arts Building, Chattanooga, Tenn. and thank him for contributing an article on Varicose Veins, and inform him that it will be published in about five months.

It was duly voted and seconded that the next meeting of the "Doc Mag" Committee will be at 7 P.M., September 30, 1959 in the Headquarters Offices, Academy of Medicine, Atlanta, Georgia.

The following articles were read for discussion by the Committee:

Hypert thyroid	Wyatt
Hypothyroid	Vansant
Bronchiectasis	Vansant
Chicken Pox	Derrick
Measles	Derrick
Scarlet Fever	Derrick
Puberty	Yochem
Senile Psychosis	Yochem
Stress Incontinence	Neal
Irregular Menstruation	Neal
Why Have a Family Doctor	Inglis
Care of the Ears	Inglis
Varicose Veins	Derrick

Dr. Glass will mail in two articles; one on Piles, and one on Thyroid Nodules.

Mrs. Grinalds was instructed to make a bound folder of each article published since the beginning of the Weekly Health Column and send one to each member of the Committee for his office waiting room.

Each member of the Committee is to bring two articles to the next meeting in September, the choice of subject is left to him.

There being no further business, the meeting was adjourned at 9:40 P.M.

GERIATRICS COMMITTEE MEETING MINUTES

THE MAG COMMITTEE ON GERIATRICS was called to order at 1:45 P.M., April 15, 1959 in the Academy of Medicine, Atlanta, Georgia by Chairman Harry Brill.

Members of the Committee present included Harry Brill, Columbus, Chairman; Edgar Woody, Jr., Atlanta, and Milton F. Bryant, Atlanta. Also present was Mr. M. D. Krueger, Executive Secretary.

Chairman Brill called on Mr. Krueger to read the minutes of the January 4, 1959 meeting of the Committee on Geriatrics which were approved as read.

COUNTY SOCIETY GERIATRICS COMMITTEE LETTER—Committee members discussed the results of a January 16, 1959 letter mailed to the presidents and secretaries of the Association's 70 component county medical societies requesting them to set up a county society Geriatrics Committee. After discussion, by general agreement, it was recommended that a new letter be drafted and sent to the presidents and secretaries of the 70 county medical societies again requesting these officers to set up county medical society Geriatrics Committees.

NURSING HOME AND CHRONIC DISEASE HOSPITALS—Chairman Brill discussed the federal and state funds that may be available through the State Health Department for the establishment of nursing homes and chronic disease additions to general hospital. He stated that these could only be obtained by communities seeking such facilities. It was felt that the Association

can best function in this area by stimulating the county society Geriatrics Committees into contacting possible sponsoring units in their area. By general agreement, this item of business was referred to the Hospital Committee of the Association for further consideration and action.

NATIONAL CONFERENCE OF THE JOINT COUNCIL TO IMPROVE THE HEALTH CARE OF THE AGED—Chairman Brill discussed the First National Conference of the Joint Council to Improve the Health Care of the Aged which is holding a meeting June 12-13, 1959 in Washington, D. C. By general agreement, it was recommended that the coordinator or director of the Association "Health Care of the Aging" program attend this meeting, if at all possible. It was further recommended that the coordinator or director of the Association "Health Care of the Aging" committee attend, if possible, the AMA Annual Session in Atlantic City to participate in a June 10 session on "New Concepts of Aging." The Committee also recommended that a transcript from this AMA meeting be obtained after the meeting and be considered for possible publication in redrafted form in the *Journal of the Medical Association of Georgia*.

GOVERNOR'S COMMITTEE ON AGING—Chairman Brill led discussion of the possibility of establishment of a "Governor's Committee on Aging" and the committee strongly recommended that the Association should approach the Governor on this matter at the earliest possible date.

HOME CARE SERVICES—Chairman Brill discussed the present home care services available to the elder citizens in Georgia. He noted that these programs are grossly inadequate in the State of Georgia. After discussion the Committee recommended that such programs should be established by the county society Geriatrics Committees in those county medical societies covering areas of jurisdiction of a population of 20,000 or over and that the Geriatrics Committee would inform and orient the society chairman of this project.

SURVEY OF AGING PROBLEMS IN GEORGIA—Chairman Brill discussed the stimulation of some type of health survey program and the committee recommended that as certain statistics were available from state agencies, both Drs. Woody and Bryant should try to assess which statistics were necessary to adequately understand the problem of the health care of the aging in Georgia. After this analysis by Drs. Woody and Bryant, they were requested by Chairman Brill to send to him an indication of what should be surveyed and how it should be done. On receipt of this material Dr. Brill will then ask the Headquarters Office to get the statistical data deemed necessary by his Committee.

AMA HEALTH CARE OF THE AGING EXHIBIT—By general agreement, Mr. Krueger was requested to inform the American Medical Association that the Medical Association of Georgia wishes to have the AMA exhibit on Health Care of the Aging for the 1960 Association Annual Session to be held in Columbus, Georgia, May 1-4, 1960.

HEALTH INSURANCE FOR AGE 65 AND OVER—Chairman Brill discussed those Health Insurance Plans including Blue Shield of Columbus, now being written for persons of age 65 and over. The Committee recommends that the Association Insurance and Economics Committee seek ways and means of getting voluntary prepaid health insurance plans underwritten in the state of Georgia for people of age 65 and over.

LIMITED PHYSICAL EXAMINATION FOR ELDERLY PEOPLE—Dr. Bryant discussed the possibility of promoting a statewide limited physical examination for persons of age 65 and over. After discussion Mr. Krueger was requested to get data from the American Medical Association on this subject for Dr. Brill, so that the Committee may be advised of what is being done in other states in this connection.

There being no further business the meeting was then adjourned at 4:30 P.M.

1959-60 ORGANIZATIONAL MEETING OF THE COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA

THE 1959-60 ORGANIZATIONAL MEETING of the Council of the Medical Association of Georgia was called to order by President Luther H. Wolff, Columbus, at 12 P.M., May 20, 1959 in the Augusta Room of the Bon Air Hotel, Augusta, Georgia.

Present, in addition to President Wolff were President-Elect Milford B. Hatcher, Macon; Immediate Past-President Lee Howard, Sr., Savannah; George L. Alexander, Forsyth, First Vice-President; Charles W. Hock, Augusta, Second Vice-President; Chris J. McLoughlin, Atlanta, Secretary; Thomas W.

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NOMINATION AND ELECTION OF COUNCIL CHAIRMAN AND VICE-CHAIRMAN FOR 1959-60—On motion (Goodwin-Williams) it was unanimously voted that J. G. McDaniel, Atlanta, be Chairman of MAG Council for 1959-60.

On motion (McLoughlin-Peterson) it was unanimously voted that Charles Andrews, Canton, be Vice-Chairman of MAG Council for 1959-60.

COUNCIL APPOINTMENT OF JOURNAL OF MAG EDITOR—On motion (Dillinger-Williams) it was unanimously voted that the present editor of MAG Journal, Edgar Woody, Jr., Atlanta, be re-elected.

APPOINTMENT OF COUNCIL FINANCE CHAIRMAN BY CHAIRMAN OF COUNCIL—Chairman McDaniel appointed Virgil B. Williams, Griffin, to be Finance Committee Chairman and Charles Andrews, Canton, and George Alexander, Forsyth, serve with him on this Committee.

The Organizational meeting of the Council was recessed at this time.

Executive Committee of MAG Meeting

Chairman of the Executive Committee of Council Luther H. Wolff, called the Executive Committee to order at 12:50 P.M. in the Augusta Room of the Bon Air Hotel, Augusta, Georgia.

Present, in addition to the Chairman were President-Elect Milford B. Hatcher, Macon; Immediate Past-President Lee Howard, Sr., Savannah; Secretary Chris J. McLoughlin, Atlanta; Chairman of Council J. G. McDaniel, Atlanta; Chairman of Finance Committee Virgil Williams, Griffin; and Mrs. Emily Grinalds of the Headquarters Office Staff.

APPOINTMENT OF TREASURER BY EXECUTIVE COMMITTEE OF COUNCIL FOR 1959-60—On motion (McDaniel-Williams) it was voted to defer appointment of Treasurer until the next meeting of the Executive Committee of MAG Council. On motion (Hatcher-Williams) it was voted that J. G. McDaniel act as Treasurer pro-tem until a Treasurer is appointed at next meeting of the Executive Committee. Secretary McLoughlin requested an audit before the appointment of a new Treasurer, and this request was granted.

SELECTION OF EXECUTIVE SECRETARY—On motion (McLoughlin-Williams) it was unanimously voted that Mr. M. D. Krueger, Atlanta, be re-appointed Executive Secretary of the Medical Association of Georgia.

DATE AND SITE OF JUNE EXECUTIVE COMMITTEE OF COUNCIL MEETING—On motion (Williams-McDaniel) it was voted that the Executive Committee Council meeting be held in Macon, June 21, 1959, at 11 A.M.

There being no further business, the Executive Committee was adjourned at 1:05 P.M.

Reconvened Organizational Meeting of Council

Chairman McDaniel called the Reconvened Organizational Meeting of the Council of MAG to order at 1:06 P.M., May 20, 1959 in the Augusta Room, Bon Air Hotel, Augusta, Georgia.

APPROVAL OF COUNCIL ON EXECUTIVE COMMITTEE ACTION—On motion duly made and seconded, the minutes of the Executive Committee of Council Meeting just held were approved as read.

APPROVAL OF COUNCIL ON EXECUTIVE COMMITTEE SELECTION OF EXECUTIVE SECRETARY—On motion duly made and seconded, the selection of Mr. M. D. Krueger as Executive Secretary was unanimously approved.

DATE AND SITE OF NEXT COUNCIL MEETING—On motion (Alexander-Williams) it was voted that the next meeting of MAG Council shall be in Dalton, Georgia at the invitation of D. Lloyd Wood, in July. On motion duly made and seconded, it was voted that the MAG Council shall meet in September at Calloway Gardens at the invitation of J. W. Chambers, LaGrange.

NEW BUSINESS—Speaker of the House Thomas W. Goodwin read a resolution that came too late to be presented to the House of Delegates as follows:

"Recent newspaper articles report numerous deaths from suffocation due to improper use of plastic laundry and dry cleaning bags. Children pull these bags over their heads in play. Static electricity and the intake of breath cause the filmy plastic to adhere closely to the face. The children are unable to tear the plastic away. Death rapidly ensues.

Unknowning parents are reported to slit these bags open and use them as bedcovering and crib tents for infants. The plastic falls or is pulled over the head of the child and he is soon asphyxiated.

WHEREAS: In view of these deaths it is proposed that the MAG go on record as opposing the continued use of plastic for laundry and dry cleaning bags until safeguards, such as multiple perforations or other adequate precautions be devised.

It is urged that special steps be taken in conjunction with the press to publicize the grave danger in permitting children to play with these bags and in using plastic material as bedcovers."

On motion duly made and seconded, it was voted that MAG Council opposes the use of plastic bags for laundry and dry cleaning, and refers this resolution to the Committee on Public Service.

President related the problems on Health Care of the Aging, and said that MAG has one year to do something about these problems. At this time, he introduced the Chairman of the Council Committee on Health Care of the Aging, John Atwater, Atlanta.

Chairman of Council Committee on Health Care of the Aging Atwater spoke on the magnitude of the problems facing this Committee. He stated that these problems are political, social, and economic. There is to be a meeting in Washington, D. C. in June, and one in Ann Arbor, Michigan in June. It would be of great value for the Chairman to attend these meetings. President Wolff commented that there are no funds allocated for the Committee on Health Care of the Aging. On motion (Dillinger-Wolff) it was voted that \$500 from the Contingent Fund be allocated to this Committee, until the next meeting of Council.

Secretary McLoughlin stated that F. G. Eldridge, Valdosta, had been called away from the meeting because of the death of his sister-in-law. It was agreed that a message of sympathy be sent to Dr. Eldridge by the Secretary.

President Wolff stated that the Constitution and Bylaws states that "Between meetings of the Executive Committee, the Chairman of the Executive Committee of Council or his duly appointed representative shall direct the Executive Secretary as to *undetermined matters of policy*." He, therefore, appointed Secretary McLoughlin to so act in his absence.

There being no further business, the meeting was adjourned at 1:25 P.M.

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"HEALTH CARE OF THE AGED"; PHOTO BY TED F. LEIGH, M.D., ATLANTA.

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THE CHOICE OF A DIURETIC WITH SPECIAL REFERENCE TO HYDROCHLOROTHIAZIDE

The basic mechanisms of electrolyte retention and diuresis are discussed.

JAMES A. KEMP and THOMAS FINDLEY, M.D., *Augusta*

GENERALIZED EDEMA IS ALWAYS of renal origin for it occurs only when the kidney receives more salt than it excretes. Sodium output drops sharply whenever the metabolic needs of the body cannot be met either because of (a) an inadequate cardiac output or (b) a reduction in effective blood volume. The kidney is unique in its ability to withstand anoxia so that it is able in time of stress to shunt large quantities of blood to organs which need it more. The means by which the kidney recognizes this need and responds to it by internal vasoconstriction are not well understood but the organ may be likened to a "built-in interne," ever ready to return saline and blood to the blood stream upon demand. There is no better index of circulatory efficiency than the presence of salt in the urine (except in Addison's disease). If the circulatory defect can be corrected by this antidiuretic device, sodium balance returns to normal; but, if not, sodium retention persists and leads to edema. The complex hormonal and neurological factors which control salt and water balance have been authoritatively reviewed by Smith.¹ Suffice it to say here that the stimulus for sodium retention appears to be a reduction in blood pressure in some critical area of the arterial tree, possibly the left auricle; that the stimulus for water retention is plasma hyper-osmolarity; and that these two sets of afferent stimuli are integrated in the hypothalamus

which in turn instructs the adrenal cortex and neurohypophysis to make appropriate changes in the output of aldosterone and pitressin respectively.

It is obvious therefore that edema can be attacked from many angles but a careful clinical analysis of the case at hand is essential to a successful outcome. It may help to look upon the kidney as an organ whose primary job is to return glomerular filtrate to the blood stream; it is in effect a sodium pump and thus diuretics increase the excretion of salt and water by inhibiting its ability to perform this essential task.² There are a number of ways in which this may be accomplished.

The Causes of Sodium Retention and Their Correction

I. Reduced Load of Filtered Electrolyte:

(1) *Failure of the systemic circulation.* Since the kidney normally resorbs more than 99 per cent of the filtered load of sodium, a one per cent drop in the rate of glomerular filtration will cause salt to vanish from the urine if tubular activity remains constant. Renal blood flow and glomerular filtration rate are sensitive indicators of changes in circulatory efficiency. Measures which augment cardiac output or which expand blood volume increase the excretion of salt.

Treatment: (a) Reduction of salt intake is of course a *sine qua non* in all types of edema.

(b) Infusion of blood, plasma or plasma substitutes; digitalis, vasopressor drugs, oxygen, antibiotics,

From the Department of Medicine, Medical College of Georgia, Augusta, Georgia.

Presented at the *105th Annual Session of the Medical Association of Georgia, May 18, 1959, Augusta, Georgia.

CHOICE OF DIURETIC / Kemp

etc. may improve circulatory efficiency.

(c) Xanthine derivatives are said to dilate the afferent glomerular arterioles and thus augment the rate of glomerular filtration but the actions of such drugs as theophylline and caffeine are complex and feeble.

(2) *Hypochloremia*. This is apt to appear as a specific phenomenon in patients given mercurial diuretics for long periods of time. These drugs impair the tubular resorption of chloride to a greater extent than that of sodium, the extra moiety of urinary chloride being excreted in combination with potassium and ammonia. Since reciprocal changes take place between the concentrations of chloride and bicarbonate in the serum, the result may be hypochloremic alkalosis. (Edema accompanied by equal degrees of hyponatremia and hypochloremia is due to water retention rather than salt depletion: the administration of hypertonic saline can only make matters worse.)

Treatment: The cations of the acidifying salts (KCl, CaCl_2 and, preferably NH_4Cl) are either poorly absorbed by the gut or are disposed of by well-known metabolic processes so that the anions become free to displace bicarbonate and in sufficient doses to lead to hyperchloremic acidosis. Acidosis in itself is not a very useful diuretic phenomenon but the increased load of filtered chloride restores responsiveness of the kidney to mercury and increases the osmotic pressure of tubular fluid. Ammonium chloride in oral doses of perhaps 6-9 gm. daily for 3-4 consecutive days each week is an effective procedure but there is good evidence that potassium salts also displace sodium and hydrogen from cells to serum and thus raise the serum concentration of sodium as well as chloride.³

(3) *Diseases of the glomerular capillaries*. In acute hemorrhagic glomerulonephritis the swollen endothelium obstructs capillary circulation; in the nephrotic syndrome thickening of the basement membrane and the epithelial foot processes occurs.

Treatment: All diuretics are ineffective in acute glomerulonephritis. The intake of salt and water must be curtailed until the proliferative reaction subsides.

ACTH and adrenocortical steroids are often effective in the nephrotic syndrome presumably because they increase the rate of glomerular filtration, diminish capillary permeability, and suppress the secretion of aldosterone. The real therapeutic objective, however, should be abolition of proteinuria rather than control of edema.⁴ New compounds are constantly appearing but a useful standard of reference is prednisone, 40 mg./day for perhaps three

weeks being a reasonable dose for the average adult. Frequently diuresis does not appear until the drug is withdrawn.

II. Increased Rate of Electrolyte Resorption:

One popular explanation of the process by which filtered sodium is returned to the blood stream states that it is exchanged for other cations, chiefly hydrogen, potassium, and ammonium. Measures which suppress the availability of these substances should therefore increase the excretion of sodium and—indirectly—that of water.

Treatment: (1) *Suppression of available hydrogen*. Under the influence of the enzyme *carbonic anhydrase*, H_2O and CO_2 unite intracellularly to form H_2CO_3 which instantaneously disassociates into H^+ and HCO_3^- . If H^+ is unavailable the limited amount of Na^+ which can still be resorbed is exchanged chiefly for K^+ so the urine will contain larger quantities of Na^+ , K^+ , HCO_3^- and hence of H_2O .

Sulfanilamide derivatives such as acetazolamide (Diamox®) are carbonic anhydrase inhibitors but the loss of HCO_3^- in the urine leads to metabolic acidosis, so they are of limited use as diuretics.

(2) *Suppression of available potassium*. An important function of aldosterone is the ionization of potassium, the only form in which it is available for exchange with sodium. Drugs which inhibit the secretion of this hormone or the action thereof will therefore reduce the amount of Na^+ which can be absorbed by cation exchange.

Amphenones depress the secretion of aldosterone by the adrenal cortex⁵ but are too toxic for clinical use. A somewhat different approach is the use of certain synthetic steroids which apparently block the sodium—retaining action of aldosterone itself^{6,7} but entirely satisfactory analogs have not yet been described.

(3) *Inhibition of other tubular transport mechanisms*. About 85 per cent of the glomerular filtrate is resorbed in the proximal convolutions and the loops of Henle without change in osmotic pressure or pH so that it is difficult to invoke exchange by them. Little is known about the processes which resorb such large amounts of electrolytes. The volume of fluid entering the distal segments, however, can be increased by raising the osmotic pressure of tubular fluid or by interfering with the machinery responsible for the passage of salt across the renal epithelium, whatever it may be.

(a) Organic mercurial compounds with at least one free valence of Hg^{++} capable of combining sulfhydryl enzymes act as diuretics by diminishing the amount of energy available to the "sodium pump" residing in the cells of the proximal convolutions.⁸ These are among the most effective agents

we have. Some of the popular preparations are:
Meralluride (Mercurhydrin®)
Mercurophylline (Mercupurin®)
Mercaptomerin (Thiomerin®)
Marsalyl (Salyrgan®)

The mercurial compounds designed for oral use have been a little too toxic for general acceptance.

(b) The synthesis in 1957 of chlorothiazide (Diuril®) by Novello and Sprague⁹ marked an important advance in clinical medicine for this proved to be a diuretic agent fully as potent as the mercurial compounds and yet effective in tablet form (the average dose is 500-1,000 mg./day). It has also interested the renal physiologists because it seems to combine the action of carbonic anhydrase inhibitors with that of mercury. Carbonic anhydrase inhibition is not a very important property, however, for large amounts are required to increase the renal excretion of K^+ and HCO_3^- . The copious outpouring of Na^+ and Cl^- which it induces resembles that seen following the injection of mercury except that the sodium and chloride outputs are of equal magnitude. Hypochloremic alkalosis therefore does not occur. Pitts⁸ showed that chlorothiazide is capable of inducing maximal naturesis and chloruresis in dogs even when the animal is under the full influence of mercury and therefore concluded that this new drug—an aromatic disulphalamyl compound—blocks still another source of energy to the sodium pump. Since large doses of it and of mercury together fail to affect the resorption of nearly half the filtered load, other mechanisms obviously remain to be described.

More recently a further refinement has occurred in the introduction of hydrochlorothiazide (Esidrix®)—a disulfonamide analog which appears to be from 10-15 times as potent as its parent substance¹. Highly effective by the oral route and remarkably free from untoward effects, even when given by vein, it appears to be the most ideal diuretic yet uncovered. Our experience with it will be presented below.

III. Increased Rate of Water Resorption:

The resorption of water in the proximal segments is apparently a process passively secondary to the active transportation of electrolytes. Concentration of urine takes place in the distal segments, however, by active processes. The antidiuretic hormone of the posterior pituitary (pitressin) apparently acts by enlarging the pores in the luminal side of the cells of the distal convolution to permit the resorption of such amounts of water as are needed to make urine isotonic with plasma. Further concentration of urine is achieved by the additional abstraction of free water in the collecting tubules through processes involving the loop of Henle. As stated above, the

output of pitressin varies with the osmolarity of plasma perfusing the hypothalamus.

Treatment: There are three ways of interfering primarily with the resorption of water:

(a) The infusion of *hypertonic solutions* (glucose, sucrose, mannitol, sodium sulfate, etc.). Rather paradoxically water output can be augmented by raising the osmotic pressure of tubular fluid in order to increase the osmotic gradient against which water resorption takes place. Parenteral therapy has obvious limitations at best. Large oral doses of urea (15-30 gm./day) sometimes promote a mild osmotic diuresis in the same fashion but the bitter taste is difficult to disguise.

(b) *Pitressin antagonists.* The adrenal cortex and the neurohypophysis exert broadly opposing effects upon water excretion. Prednisone is said to potentiate the activity of mercury and chlorothiazide⁷ but the mechanism is unknown.

(c) *Inhibition of the supraoptic nuclei.* Drugs are badly needed which will selectively suppress the production of pitressin but to date the only reasonably satisfactory preparation is alcohol.⁹ Whiskey (1-2 oz. every 4-6 hrs.) is a moderately useful adjunct in the management of hyponatremic edema but here there are ethical considerations too.

Chlorothiazide and Hydrochlorothiazide*

This study concerns itself primarily with 30 hospitalized patients who had edema of variable kind and degree. Four of them had the nephrotic syndrome due to undetermined cause, one had cirrhosis of the liver, two had hypoalbuminemia due to malabsorption, and the rest congestive heart failure of different etiologies. Inasmuch as adjunctive therapeutic measures (bed rest, digitalis, variable degrees of sodium restriction, etc.) were used whenever indicated, this report makes no pretense of being a controlled metabolic study. Rather it is a reflection of the effects which may be anticipated in a course of an active ward experience. The analyses for sodium and potassium were determined by the Beckman flame photometer, of chloride by the methods of Schales and Schales, of CO_2 by conventional gasometric techniques.** The oral dose of chlorothiazide (Diuril®) was 500 mg., of hydrochlorothiazide (Esidrix®) 50 mg., each twice daily.

Treatment of the 30 patients with hydrochlorothiazide (Esidrex®) for from 10-14 days was completely effective in 26, failure occurring in two of them with arteriosclerotic heart disease, one with panmyelosis and edema resulting from high cardiac output, and one with nephrotic syndrome who failed to diurese satisfactorily despite a marked

* Kindly supplied by Ciba Pharmaceutical Products, Inc.
** We are greatly indebted to Barbara Fowler and Judith Oblesby for the analytical work.

increase in sodium excretion. Weight losses varied 2 to 44 kilograms. Daily urine volume increased by an average of 1,300 cc. The urinary electrolyte response in eight cases is depicted in Table 1.

TABLE I

Increase in 24 hour urine electrolytes during initial 48 hours of therapy with 100 mg. hydrochlorothiazide, expressed in milliequivalents and as per cent of baseline excretion before treatment.

Patient	Sodium		Potassium		Chloride	
	mEq.	%	mEq.	%	mEq.	%
1. Nephrotic Syndrome	60	670	49	88	95	244
2. Nephrotic Syndrome	26	32	51	65	32	46
3. Congestive Heart Failure	239	1086	39	150	104	315
4. Congestive Heart Failure	162	193	19	42	173	186
5. Congestive Heart Failure	170	129	8	67	160	136
6. Congestive Heart Failure	303	152	0	0	174	94
7. Cor Pulmonale	41	62	13	10	56	46
8. Hypoalbuminemia	347	551	47	392	342	519

Serum electrolyte patterns were determined in 18 of these subjects on the third and tenth days of therapy (Table 2). The averages suggest a tendency toward hyponatremia and hypochloremic alkalosis, but the changes are minimal indeed. A mild azotemia

TABLE II

Serum electrolyte changes with administration of 100 mg. hydrochlorothiazide daily.

Patient	Serum Na+ (mEq/L.) Day			Serum K+ (mEq/L.) Day			Serum Cl- (mEq/L.) Day			Serum HCO ₃ (mEq/L.) Day		
	0	3	10	0	3	10	0	3	10	0	3	10
1	136	132	130	4.3	6.8	4.6	106	102	100	26	23	22
2	131	140	134	4.7	3.8	6.2	100	98	102	30	30	31
3	132		139	5.1		4.6	97		96	29		31
4	139	128	129	4.6	4.2	5.0	101	91	83	25	34	28
5	136	131	135	4.3	3.3	3.8	100	92	93	25	33	37
6	128	126	136	5.2	4.3	5.5	93	93	106	28	35	35
7	139	140	131	4.4	4.3	4.6	109	105	98	18		31
8	139	134		5.0	3.6		101	95		29	29	
9	141	133	137	4.5	4.7	4.4	112	106	106	24	12	25
10	143	140		5.0	5.2		103	100		33	27	
11	138	135	137	3.6	5.3	5.0	107	105	111	26	33	26
12	133	131	127	3.4	5.3	5.8	102	92		27	26	26
13	142	136		3.3	5.3		103	97		27	34	
14	132	134	139	3.6	3.3	3.9	95	98	99	27	26	28
15	138	135	130	4.2	4.3	5.3	107	106	105	21	18	27
16	142	135		4.1	4.7		105	96		29	29	
17	140		135	5.2		4.5	98		94	35		37
18	137	131	128	4.3	3.5	3.5	92	95	84	24	29	31
Average	137	134	133	4.3	4.5	4.8	102	98	98	27	28	30

was seen in those patients who developed weakness and postural hypotension, phenomena due evidently to the hypovolemia noted by Fries.¹⁰ Table 3 shows the significant rise in hematocrit which occurred in our additional non-edematous, mildly hypertensive individuals who received hydrochlorothiazide for two weeks; a few random blood volume determinations by the Evans blue technique also confirmed the shrinkage in blood volume which accompanied reduction in arterial blood pressure and the appearance of postural syncope.

Although significant depletion of serum salt was not seen during the period of this study, it has been encountered subsequently on several occasions, with

TABLE III

Rise in hematocrits during chronic administration of hydrochlorothiazide in non-edematous patients.

Day of Treatment	1	2	Patient 3	4	Average
0	40	52	36	38	42
3	45	57	45	45	48
14	47	54	45	43	47

clinical improvement upon administration of hypertonic saline.

Congestive Heart Failure

Chart 1 shows the typical response to Esidrix® of a patient with congestive heart failure. The

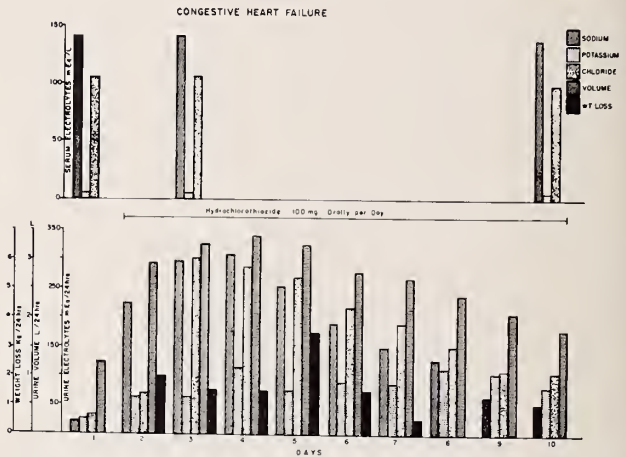


Chart 1: Urine electrolyte excretion and weight loss in congestive heart failure with treatment with hydrochlorothiazide.

markedly increased excretion rates of sodium and chloride were of equal magnitude and no important changes occurred in the serum electrolyte pattern. The output of potassium was increased only slightly.

The Nephrotic Syndrome

On the whole, nephrotic edema is less responsive than that of cardiac origin. Chart 2 illustrates a typical reaction to oral Esidrix® and may be compared with that of a cardiac patient in Chart 1.

Comparison of the Two Drugs

No studies were made on normal subjects but in

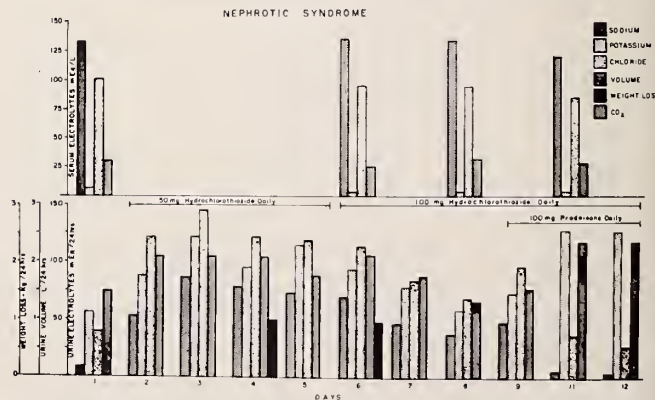


Chart 2: Urine electrolyte excretion and weight loss in the nephrotic syndrome with treatment with hydrochlorothiazide.

three patients with heart disease who had responded satisfactorily to Diuril® (1,000 mg. daily); no significant increase in water or electrolyte output occurred on change to Esidrix® (100 mg. daily). Another such subject who had been rendered edema-free on a 1,000 mg. sodium intake and a 100 mg. dose of Esidrix® daily was placed on a diet containing 10 gm. of NaCl daily. After a loading period of three such days, 1,000 mg. of Diuril® daily was given for three days, then 100 mg. of Esidrix® for three more. Chart 3 shows that both drugs enabled the patient to handle the salt load nicely and that

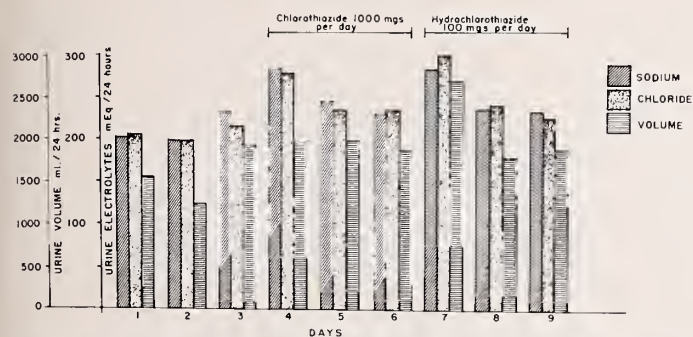


Chart 3: Urine electrolyte excretion and urine volume in patient receiving 10 gm. sodium chloride daily; comparison of chlorothiazide and hydrochlorothiazide.

Esidrix® is at least ten times as potent milligram-for-milligram as its analog Diuril®.

The Intravenous Use of Hydrochlorothiazide

Esidrix® was given intravenously to six mildly hypertensive subjects with normal renal function and no edema in order to determine the magnitude and duration of action. The patients were on a regular hospital diet but fluid intake was restricted to 100 cc./hr. for the duration of the experiment. After a two hour control period four patients received 50 mg. of the drug, the other two were given 100 mg. and urine collections were continued at hourly intervals for 8-15 hours thereafter. Chart 4 shows a typical response to the smaller dose which was fully as great as that to the larger. The maximum effects occur in two hours, are well sustained for eight hours, and in one patient studied for a longer period of time, persisted for about 15 hours. The injections were well tolerated except that postural hypotension, maximal at about 12 hours or when the greatest salt and water loss had occurred, was seen in some patients. One subject whose urinary volume exceeded his intake by 2,750 cc. experienced severe symptoms but he was fully recovered some 6-8 hours later.

Discussion

The introduction of chlorothiazide greatly improved the treatment of edema, particularly that due to congestive heart failure. In our hospital the consumption of mercurial diuretics dropped from 705

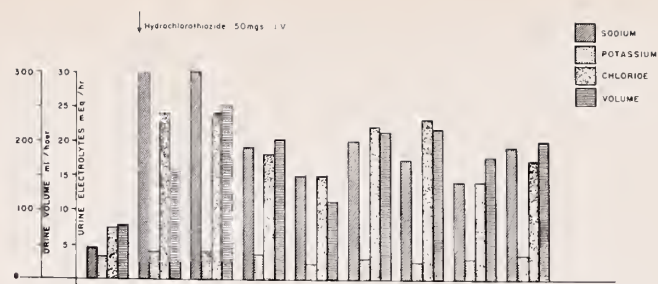


Chart 4: Urine electrolyte excretion and urine volume with intravenous dose of hydrochlorothiazide.

cc. in 1957 to 163 cc. in 1958. Toxic effects have been minimal. Some patients refractory to mercurial diuretics have responded to chlorothiazide. Animal experiments suggest that hydrochlorothiazide is 10-15 times as effective as its parent analog on a weight basis and leads to less potassium-wasting. Clinical studies confirm the feeling that the kaliuretic effect of this drug is less marked than the naturetic, chloruretic, and diuretic properties. Hypokalemia was encountered in only one of our patients. The marked weakness and postural hypotension occasionally seen are thought to be related to hypovolemia rather than to potassium deficiency. This may constitute a hazard to the ambulatory patient but explains why the drug is thought to be a useful adjunct to other measures in the treatment of hypertension. Not all edematous subjects responded maximally to either analog but hydrochlorothiazide is the most satisfactory diuretic drug available today.

Summary

1. The renal mechanisms responsible for edema formation and the pharmacology of diuretic measures are discussed.
2. Hydrochlorothiazide (Esidrix®) is the most effective diuretic agent available today. On a weight basis it is at least 10 times as potent as chlorothiazide (Diuril®). It is superior to mercurial drugs in that it augments the excretion of sodium and of chloride equally.
3. Esidrix® is capable of diminishing blood volume to the point of which postural hypotension of clinical importance may appear.

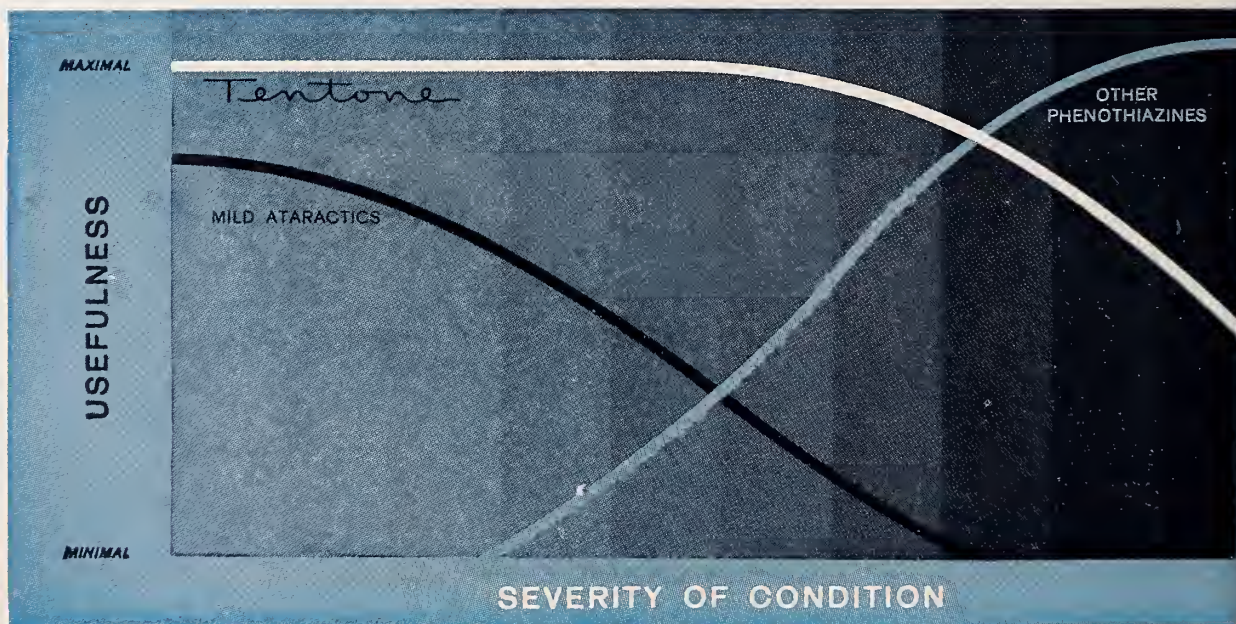
Medical College of Georgia

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INTERNAL CAROTID ARTERY INSUFFICIENCY

Encouraging results are reported in the surgical treatment of this complication of atherosclerosis.

GARLAND D. PERDUE, M.D., *Atlanta*

“STROKE” IS THE THIRD leading cause of death in the United States^{1,3}, and many patients die of respiratory, circulatory, and nutritional complications which are usually listed under other headings. In addition, an enormous toll is taken in the form of chronic, disabling handicaps. These are not limited to the elderly, but often occur in active people in the “prime of life.” In the past, enthusiastic treatment has often led to partial or near-complete recovery, but generally the outlook has been so dim as to be discouraging to doctor and patient alike.

In recent years, however, newer knowledge has given rise to the hope that strokes due to thrombotic occlusion in vessels supplying the brain—the most common cause—may often be aborted or prevented entirely. The carotid artery may be taken as an example because of the frequency of its involvement and the ease with which it may be investigated.

The occurrence of “stroke” due to occlusion of the carotid artery in the neck has been known⁴ but poorly appreciated until recent years.² It now appears that one-fourth or more of stroke victims have their disease process localized to the accessible portion of the vessels in the neck^{7,12}. The occurrence of cerebral ischemic symptoms analogous to angina pectoris and intermittent claudication is also well-documented⁹, and in many instances appears to be the result of reduced blood flow through a locally stenotic segment of the vessel. Added importance is given this knowledge by recent technical advances in vascular surgery which often permit restorative reconstruction of a blood vessel. Such an undertaking, however, presupposes that reconstruction must be done prior to the occurrence of major areas of infarcted tissue

leading to irreversible damage. Advances in diagnostic techniques now permit making the diagnosis of insufficient blood flow in many patients prior to the onset of irreversible infarction.

The pathologic basis for insufficiency of blood flow due to a localized, segmental obstruction lies in the tendency to localized deposition of atherosclerotic plaques near the bifurcation of larger and intermediate-sized blood vessels. In the carotid artery this begins often as a solitary plaque in the internal carotid just distal to the bifurcation. All degrees of obstruction may be seen, ranging from the solitary plaque to extensive atheromatous deposition and complete thrombotic occlusion of the vessel (Figure 1). Progressive deposition of atheromata, subintimal hemorrhage, and superimposed thrombi all may contribute to progressive occlusion of the vessel. In addition, the superimposed thrombus may often serve as a source for distal embolization². Either complete occlusion of the internal carotid at the bifurcation or occlusion of a more distal vessel by an embolus arising from this source may produce cerebral infarction with the accompanying fixed, permanent neurologic deficit.

The symptoms produced by insufficiency of arte-

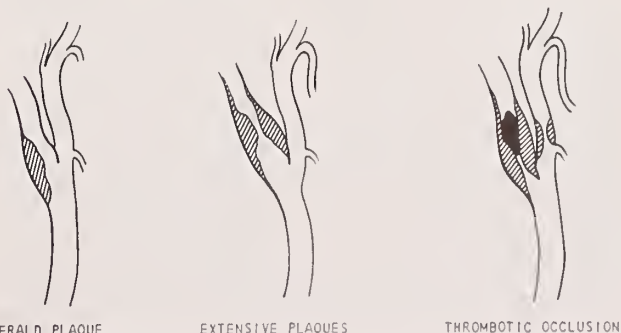


Figure 1 a: Illustration of location of obstructions in internal carotid artery.

From the Joseph B. Whitehead Department of Surgery, Emory University School of Medicine, Atlanta, Georgia.
Presented at the *105th Annual Session of the Medical Association of Georgia, May 19, 1959, Augusta, Georgia.

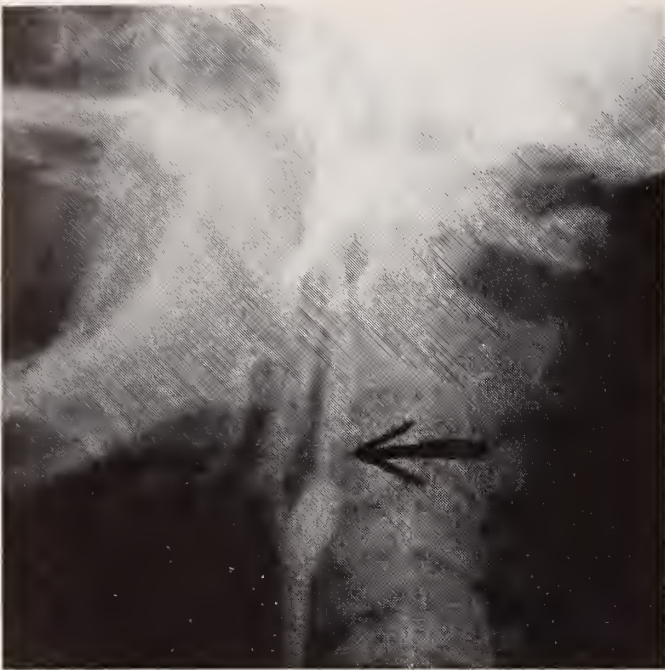


Figure 1 b: Radiographic illustration partial obstruction internal carotid artery.

rial blood flow depend on the degree of narrowing and the adequacy of collateral circulation. Obviously, complete occlusion of the vessel combined with poor collateral circulation will result in infarction of the tissue supplied by the vessel, which in the carotid artery means a stroke. In the past, transient episodes of motor or sensory loss, aphasia, and other neurologic symptoms have been vaguely classified as strokelets, cerebral vasospasm, etc. Fixed but minor neurologic deficits also occur, and it seems clear that many of these episodes are due



Figure 1 c: Radiographic illustration complete obstruction internal carotid artery.

to carotid artery insufficiency. This is often emphasized by the subsequent occurrence of fixed neurologic deficit identical to the previous transient ones when complete occlusion eventually occurs. In fact, the majority of full-blown strokes are preceded by one or more transient and/or minor episodes before the final catastrophe occurs^{5,7}. The symptoms most often occurring in carotid artery insufficiency are outlined in Table I. Remembering the crossed localization of cerebral function, motor and sensory disturbances occur on the side opposite to the hemisphere with insufficient blood flow. When monocular blindness occurs, it is on the same side as the occlusion due to loss of blood flow through the ophthalmic artery. Aphasia occurs only when the dominant hemisphere is the site of insufficient blood flow.

The important feature of these symptoms in regard to prognosis for treatment is that they are transient. Full or nearly full recovery follows each episode unless the obstruction is complete and cerebral infarction has occurred. Minor degrees of fixed neurologic deficit may persist, however, and this may be gradually cumulative. The episodes may be precipitated by changes in posture (drop in blood pressure)⁸, sleep (reduced blood flow), excitement or increased exertion, or a change in position of the neck leading to further diminution in the caliber of

TABLE I
Symptoms in Carotid Artery Insufficiency

- | |
|--|
| 1. Hemiparesis or monoparesis (transient)—side opposite lesion. |
| 2. Hemiplegia or monoplegia (transient)—side opposite lesion. |
| 3. Aphasia when dominant hemisphere involved. |
| 4. Sensory loss or paresthesia (transient)—side opposite lesion. |
| 5. Monocular blindness (10-15%)—same side as lesion and side opposite to motor or sensory disturbance. |
| 6. Gradually cumulative neurologic deficit in many patients. |
| 7. Psychic changes. |
| 8. Headaches. |

the vessel lumen. They may also be induced by iatrogenic decrease in blood pressure and acute reductions in cardiac output.

The physical findings may indicate a minor neurologic deficit, or none may be present. Diminution in internal carotid pulsation may be difficult to determine by palpation because of proximity to the common and external carotids. Palpation in the tonsillar fossa is sometime more helpful than palpation in the neck. Crevasse and Logue¹ have emphasized the importance of the murmur usually heard over the carotid bulb. This murmur is characteristic, and is perhaps the most important single finding leading to a clinical diagnosis. The murmur is more frequently continuous, but is occasionally systolic only. Compression of the contralateral carotid may reproduce the symptoms or result in syncope when applied for 10-20 seconds¹⁴. The measurement of the differential pressure in the retinal arteries by the ophthalmodynamometer is a limited but useful aid³.

Lastly, the diagnosis may be confirmed by cerebral arteriography.

As previously emphasized, effective treatment depends on its institution before the occurrence of cerebral infarction with severe, fixed neurologic deficit. The accessibility of the cervical carotid artery combined with the frequent localization of the obstructive process to this area, coupled with the dire consequences of progressive occlusion, make this an ideal situation for surgical reconstruction of the vessel. It is recommended that those patients who have transient symptoms of cerebral ischemia, no severe fixed neurologic deficit, and evidence of carotid artery occlusion should be strongly considered for reconstructive surgery (Table II).

TABLE II
Criteria for Operation

1. Recurrent episodes cerebral ischemic symptoms.
2. Persistent neurologic deficits are minor or absent.
3. Physical findings and arteriographic confirmation of partially occluded internal carotid artery in the neck.
4. ? complete occlusion.
5. Absence of major contraindications to surgery.

The operative technique most commonly employed is thrombo-endarterectomy, and this procedure is illustrated in Figure II. Some instances may arise where excision of a local area with artery grafting, or an arterial by-pass graft, would be desirable. We have not as yet found this necessary, and have depended on the simpler procedure of thrombo-endarterectomy.

Our results tend to confirm those generally reported^{10,11}. About two-thirds to three-fourths of the patients operated on are markedly improved or completely relieved of the symptoms of transient cerebral ischemia. The remaining group are not improved or only slightly so, but we have had no patient who was made worse by the procedure. Some patients are temporarily worse, and improvement may be progressive for several weeks after the operation. When complete occlusion of the vessel has occurred, the results generally are not impressive. Selection of those patients who have only partial obstruction gives far more favorable results. Long-term follow-up is not yet available in any series, but the incidence of later development of full-blown strokes seems markedly reduced.

Summary

Partial or complete occlusion of the internal carotid artery is a frequent occurrence, and is usually localized to a short segment of the vessel in its accessible portion in the neck. This is an important cause of symptoms of cerebral ischemia which may be transient when the occlusion is incomplete. Complete occlusion in most instances results in cerebral infarction with a typical clinical "stroke."

Diagnosis is made by the history and the findings

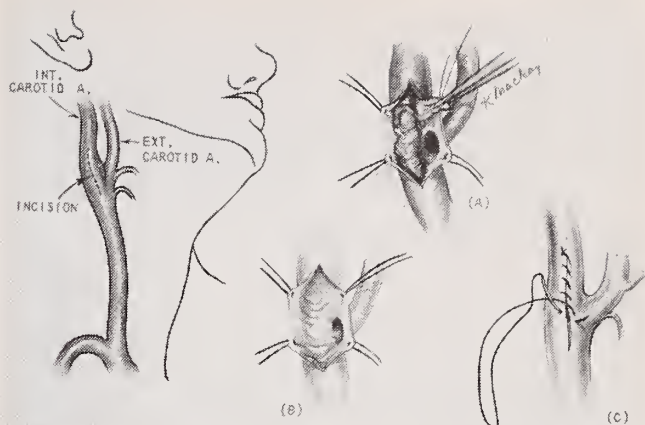


Figure II: Drawing illustrating technique of thrombo-endarterectomy.

of a murmur over the affected vessel, syncope on compression of the contralateral vessel, and arteriographic evidence of obstruction to blood flow localized to the cervical internal carotid artery.

Surgical reconstruction of the vessel with restoration of blood flow is an effective method of treatment in a large percentage of patients, and should be advised to a patient with transient cerebral ischemia without severe fixed neurologic deficit.

Emory University Clinic

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CALCIFICATIONS IN THE LIVER

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This infrequent finding may be helpful in the diagnosis and management of difficult cases.

CALCIFICATIONS THAT MAY be seen on X-ray in the right upper quadrant of the abdomen are more frequently due to calcified costal cartilages, gallstones, pleural or pulmonary calcifications, than they are due to calcifications in the liver. By the use of adequate positioning of the patient with lateral and oblique views, the use of gall bladder dye, and occasionally tomography, a certain number of calcifications can be accurately localized to the liver. When these are seen they are an unexpected finding in almost every case. They are very often ignored as incidental findings of no significance insofar as the manifestation of active disease is concerned, and are usually considered to represent healed scars of tuberculosis, hydatid cysts, amebic or pyogenic abscesses, although occasionally they may be due to hepatic lithiasis or active neoplasms. If they are due to the latter two conditions they may be of marked significance from the standpoint of the patient's prognosis. In some cases the correct etiologic diagnosis may be suspected from radiological characteristics of the calcified lesions but histologic examination of material from the involved liver is necessary to establish a definite diagnosis. Our interest in this condition was aroused as a result of an experience in which intrahepatic calcifications were an incidental finding to the present illness of the patient. Because of our curiosity, however, and because of our interest in needle liver biopsies, we were able to establish the correct diagnosis which altered the patient's prognosis tremendously.

Case I—O. B. L. (E. U. Hosp. No. 94-448-U). This 70-year-old lady was admitted on December

30, 1957 for diagnosis of an episode of hematemesis that had occurred seven days previously. She stated that she had experienced mild to moderate postprandial epigastric aching for eight months, worse when her stomach was empty and relieved by alkali. One week before admission she became nauseated and vomited blood that was described as dark red, with clots and some coffee ground material.

She was hospitalized elsewhere for two days and received two units of blood. There had been no further hematemesis and she was not aware of any change in the color of her stools. She had had no weight loss or change in her bowel habits. At the time of admission to the hospital she had only mild epigastric discomfort which was immediately relieved by antacids and she did not appear ill. Physical examination revealed the presence of a 9 x 9 cm. mass in the mid-epigastrium which descended on respiration and appeared to be an enlarged left lobe of the liver. The right lobe was not enlarged and was palpated 1 cm. below the costal margin on inspiration. No other abdominal masses were palpated and pelvic and rectal examinations were normal. Her hemoglobin was 11 grams per cent, stool guaiac was 3 plus, and liver function studies revealed 20 per cent of Bromsulphalein® in 45 minutes. She had a mildly diabetic glucose tolerance curve. Serum alkaline phosphatase, serum bilirubin, serum albumin and globulin, cephalin flocculation and thymol turbidity tests were normal. Barium studies of her gastrointestinal tract failed to reveal any abnormalities that might account for her recent bleeding episode but an incidental finding was the presence of clumps of mottled calcifications in the right and left lobes of the liver. Initially it was thought that pancreatic calcifications were present but lateral studies localized these to the liver. Gall bladder series was

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normal. Intermediate strength PPD and histoplasmin skin tests were negative. The patient responded very well to an ulcer regimen and her recent episode of hematemesis might well have been ascribed to a superficial peptic ulcer that defied radiologic visualization had it not been for the enlarged left lobe of the liver and the intrahepatic calcifications. On the eighth hospital day a percutaneous needle liver biopsy was performed in the mid-epigastric area and an adequate specimen was obtained from the enlarged left lobe of the liver. The pathological examination revealed slight fatty metamorphosis. On the 12th hospital day the patient was fluoroscoped to determine which would be the most successful angle for directing a biopsy needle to encounter one of the calcified areas. On the first two attempts the needle encountered resistance and no specimen was obtained. The needle was directed slightly more superiorly and a very satisfactory specimen was then obtained, histologic examination of which revealed mucous-producing adenocarcinoma, metastatic in liver.

The patient's family was informed of this finding and she was dismissed from the hospital on an ulcer regimen with continued improvement for a month or so. However, she stated that she would go two or three days without any discomfort and then the epigastric aching would occur after midnight with only poor relief from milk. After a few more months she began to have more discomfort and her liver gradually enlarged. Two repeat G. I. series were performed which revealed no evidence of tumor or ulcer. During the six months after the establishment of the diagnosis of metastatic cancer she remained active and had no more discomfort than many patients with mild to moderately severe ulcer pains. Bleeding did not recur. After this six months period she gradually deteriorated for a three month period, developing pleural effusions, ascites, and radiologically visible bilateral pulmonary interstitial densities. She was hospitalized for terminal care on October 7, 1958 and died 10 days later. At autopsy the liver was not overweight but its size and shape were markedly distorted because of the presence of several masses, some of which contained spicules of calcification. Sections of the liver in some portions were made with a hack saw because of the bony consistency in these areas. Microscopic examination of the liver revealed very heavy fibrosis with areas of calcification and in the middle of the fibrous tissue there were small groups of tumor cells present. A large nodule of metastatic tumor was noted in the spleen and the lungs were heavily invaded with metastases. Metastatic changes were found in abdominal lymph nodes, diaphragm, mesentery, pleura, and bone. The pancreas, stomach, small intestine,

and large intestine revealed no evidence of neoplastic involvement. No source for the episode of G. I. bleeding that occurred over nine months before death could be found. The final anatomical diagnosis was bile duct carcinoma.

Comment: It was very important to the family to have an accurate prognosis as to the patient's longevity and her relatives were better able to provide her with care and comfort since they were forewarned well in advance of her approaching death.

Case II—A. M. J. (E. U. Hosp. No. 93-701-U). Shortly after the death of the first patient two additional patients with unexplained intrahepatic calcifications were admitted to the hospital. An exploratory laparotomy had been performed on one of these on February 15, 1958, because of long standing obstructive jaundice and marked hepatomegaly and a very hard lesion was found in the dome of the liver extending anteriorly, posteriorly, and laterally. Using a Vim-Silverman needle the surgeon removed a core of this material from the lesion, pathologic examination of which revealed adenocarcinoma. At this time X-rays revealed no evidence of calcifications but nine months later extensive calcifications were visualized radiographically throughout the right lobe of the liver. The patient died six weeks later. The liver was tremendously enlarged and its shape was altered because of the presence of a voluminous mass within its right lobe which superficially presented several nodularities about 2 to 3 cms. in diameter alternating with congestive liver tissue. Cut sections showed the presence of small spicules of calcium. Examination of the G. I. tract revealed a carcinoma of the rectum which had defied earlier diagnosis by barium enemas and by sigmoidoscopic examinations on repeated occasions by her physician and by a proctologist. Microscopic examinations of sections from the tumor of the liver presented similar structures to the adenocarcinoma of the rectum and final diagnosis was adenocarcinoma of the rectum with metastases to the lymph nodes, peritoneum, liver, right adrenal, left lung, abdominal wall, and diaphragm.

Comment: There have been a number of cases of calcified rectal carcinomas reported and it is no surprise that metastases from a rectal carcinoma should likewise undergo calcification. This association has been noted in five of six cases of calcified metastatic carcinoma to the liver found in the literature.

Case III—A. L. P. (E. U. Hosp. No. 15-521-U). This 61-year-old single unmarried female had a myxochondro carcinoma of the salivary gland excised in 1942 and has had multiple recurrences subsequently. Thirteen years after the first operation she was noted to have hepatomegaly which increased progressively and became distinctly nodular over the

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next three years at which time diffuse irregular calcifications were visualized throughout most of the major portion of the right lobe of the liver. A percutaneous needle liver biopsy was performed which revealed adenocarcinoma compatible with salivary gland origin. This patient is still living but has developed evidences of other metastases.

Comment: If the intrahepatic calcifications in this patient are due to salivary gland metastases this will be unique since we have found no similar case reported in the literature.

Discussion

Review of the literature yields very few cases of calcifications in the liver resulting from metastatic carcinoma. Five cases have been reported^{1,2,3} from primary tumors of the large intestine, one from papillary cyst adenocarcinoma⁴ of the ovary, and one in whom autopsy was not done and the primary not located². It was quite surprising to find that this condition appears to be so rare.

Calcified liver nodules from metastatic melanoma primary to the eye has been reported in a case⁵ in which the eye had been excised 15 years previously. X-ray demonstrated numerous calcified areas in the liver. At laparotomy they varied from 3 mm. to 10 cms. in size and microscopic examination of excised nodules revealed that they were melanomas. There was no hepatomegaly. The patient was actively working as a traveling salesman at the time of the case report. A single case of Hodgkin's Disease is reported⁶ in which the greater part of the liver was stony hard. Between large clumps of calcareous matter were small islands of atrophic or degenerated liver tissue without any signs of inflammation. However, involvement of the liver with Hodgkin's Disease was not described and the cause of the calcification in this case was not determined.

Primary liver cell carcinoma appears to be an even rarer cause of calcification. Five cases were found in the literature^{7,8,9}.

Benign tumors of the liver may become calcified, and they are usually cavernous hemangiomas¹⁰. These are characterized radiologically by numerous trabeculations arising and radiating from a common center. If hemangioma is suspected in a given patient needle liver biopsy would be attended with the increased risk of hemorrhage and would probably best be avoided.

Calcifications that occur in hepatic involvement with tuberculosis represent the healed scars of limited hematogenous spread occurring during the primary infection. These appear as small calcified nodules scattered throughout the liver and the spleen and present quite a distinct radiographic appearance

being easily differentiated from the more diffusely scattered clumps of finer calcification seen in cases of metastatic disease. Similar lesions probably result from histoplasmosis and this type of calcification is probably more frequently encountered throughout the Southeastern United States than other types.

Solitary calcified lesions of larger size are generally attributed to the hydatid cyst of *Echinococcus* disease. Some authors¹¹ state that *Echinococcus* disease is probably the commonest cause of calcification within the liver. Its shape is usually oval or round and the calcium deposition occurs in the capsule surrounding the mother sac producing a calcified shell surrounding the cyst. Since healed amebic abscesses are said to produce calcification in rare instances, it would be difficult to differentiate these two conditions from radiographic studies alone. If the patient had not been out of the continental United States one might think that amebic abscess might be more common in a case with such radiographic characteristics. Healed syphilitic gumma might also be suspected in the patient with a solitary oval lesion of this size.

Hepatic calculi may account for some cases of calcifications in the liver with or without cholelithiasis. Some of these liver stones are actually formed within the intrahepatic biliary passages although the majority probably gravitate superiorly following their origin within the gall bladder. They may be firmly fixed within the intrahepatic ducts, may vary widely in size, and probably have multiple etiologies among which are infection, stasis, disturbed cholesterol metabolism, and abnormalities in the chemistry of the bile. The ones that are radiographically apparent have a heavy calcium content and the radiologic appearance is described¹² as spheres with an outer shell of rather dense calcification while the core is much less opaque and is studded with round areas of radiolucency, probably due to irregularity in the deposition of the calcium. These may be asymptomatic or they may produce disastrous liver destruction due to obstruction and resulting infection.

Conclusion

Calcifications in the liver occur infrequently and are therefore an unexpected X-ray finding in most cases. Further investigation of the calcifications led to the diagnosis of metastatic carcinoma in the first case presented, before there was other clinical evidence of this diagnosis. As a result the family was able to be given an accurate prognosis as to the patient's longevity six months in advance of her deterioration.

Calcifications in the liver in the second case report followed the pattern of five previously reported cases of metastatic adenocarcinoma resulting in in-

trahepatic calcification when the primary tumor was in the large intestine.

The liver metastases in the third patient are compatible with salivary gland origin and no similar cases have been found in the literature.

The differential diagnosis of calcifications in the liver has been discussed.

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UNFIT DRIVERS ARE POTENTIAL MURDERERS

ENTHUSIASM FOR THE proposal to permit traffic court judges to require physical and psychological examinations of traffic violators—at the judge's discretion—is more than justified.

Experience has proved, and studies bear this out, that many offenders—especially repeaters—are physically or mentally unfit to drive a car. That being true, they are dangerous to public safety. Many are potential murderers, a fact which statistics also prove.

The Fulton County Medical Society and Grady Hospital will cooperate with the city on the plan. The society has been studying it for several years, culminating in the proposal approved by the police committee of the aldermanic board recently.

Such a widespread program as proposed does deserve financial support from automobile manufacturers, insurance companies, and health services. Death of 40,000 Americans a year is the shameful fact which concerns them as well as the public. Killing of 72 people on Atlanta streets last year shows this to be a good place to start.

Since most accidents are traceable to driver error, a study of drivers themselves should aid in finding the

cause. If examinations can show up unfit drivers before they are allowed further to endanger their own and others' lives, much mayhem can be prevented.

It is encouraging to note that the medical profession is taking the lead in a program which affects the welfare, even the life, of every citizen. The committee of doctors, headed by Dr. Elbert Van Buren, has acted in the public interest.

In this and other aspects of mental health, medical science can contribute greatly. The relationship of crime and mental illness has been well established. It is being acknowledged through such agencies as the Chicago Municipal Court's Psychiatric Institute, which is becoming a major adjunct to crime prevention in that city and which has devoted attention to the traffic problem, among others.

We look forward to the day when psychiatry and medicine can achieve maximum effectiveness in helping to solve the complex problems of human relationships in today's society. We're glad to see such signs of progress as this and the recent study of Milledgeville State Hospital.

— *The Atlanta Constitution*

GASTRECTOMY IN THE TREATMENT OF DUODENAL ULCER

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SURGERY HAS BEEN successfully applied to the treatment of duodenal ulcer for many years, but the ideal surgical treatment is apparently yet to be found. Distressing postoperative symptoms directly related to the surgical operation are still all too common, and at times the post-gastrectomy state is, in itself, a very disabling illness. A number of different surgical technics have been devised for the treatment of duodenal ulcer, and if one peruses the recent surgical literature, he can find documentary evidence to support the claim that each of them is the best procedure. Its proponents hold that it is best because it is safer, or because it is followed by a lower incidence of recurrent ulceration, because it results in a lower incidence of the post-gastrectomy "dumping" syndrome symptoms, because digestion and absorption of food are better, or because iron absorption is better. One of the striking features of such a perusal of the literature is the absence of studies specifically designed to carefully compare the various methods of treatment with one another on a truly objective basis.

Objective comparison of a number of types of surgical operations one with another can be best made if all of the operations under study are performed on patients in the same population group, during the same period of time, and if the assignment of operations to specific patients is made purely on the basis of chance. Evaluation of results must be based as much as possible on objective data collected in the same manner on all patients. Subjective data obtained from the patient by questionnaire or interview must be obtained by an investigator without personal bias in regard to the various oper-

An objective evaluation of four of the currently popular surgical procedures used in the treatment of duodenal ulcer.

ations who does not know which of the operations the patients have had.

It occurred to us that at the Eugene Talmadge Memorial Hospital of the Medical College of Georgia there existed an excellent opportunity to make an unbiased comparison of some of the operations used in the treatment of peptic ulcer. This is true since almost all of the patients on general surgery are "staff patients." Therefore, it would be possible to assign carefully selected operations to patients on the basis of chance, since it is possible to readmit patients to the hospital for follow-up studies without causing undue financial hardship.

Four operations were chosen for comparison. The first is a 75 per cent distal gastrectomy with a Billroth II type of reconstruction (Figure 1). The gastrojejunal anastomosis is posterior to the transverse colon and is made as close to the duodenojejunal junction as possible. A Hoffmeister closure is performed on the lesser curvature side of the residual stomach pouch so that the resulting gastrojejunal

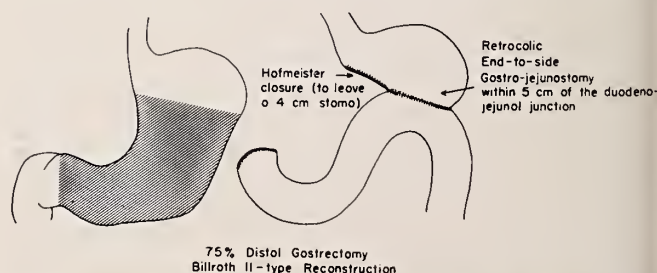


Figure 1: Seventy-five per cent distal gastrectomy, Billroth II-Type reconstruction.

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stoma is only four centimeters long. This operation was chosen because, for many years, it has been the standard operation used in the treatment of peptic ulcer. The incidence of recurrent ulceration following it is very low; but it is not an ideal operation because there is a fairly high incidence of the post-gastrectomy "dumping" syndrome following it. In addition hypochromic anemia and failure to maintain a normal body weight are fairly common.

The second operation is a 75 per cent distal gastrectomy with a Billroth I type of reconstruction (Figure 2). Here again a Hoffmeister closure is performed on the lesser curvature side of the residual gastric pouch to leave a stoma on the greater curvature side approximately the same size as the duodenal stoma for anastomosis to the duodenum end-to-end. This operation was chosen because it has recently become more popular in the treatment of peptic ulcer as a result of the reports of Harkins and his associates^{3,4}. Several advantages are claimed for this operation. It is said to be technically easy to perform, and the danger of leakage from a duodenal stump is non-existent. It is said that the nutritional status of the patients appears to be superior. Also, it is said that experimental evidence tends to indicate that the Billroth I anastomosis—indeed the incidence of recurrent ulceration in Harkin's series was only 3.5 per cent, a respectably low figure.

The third operation is a 50 per cent distal gastrectomy with a Billroth II type of reconstruction combined with a bilateral subdiaphragmatic vagotomy (Figure 3). Here again the gastrojejunal anastomosis is made posterior to the transverse colon as close to the duodenojejunal junction as possible, and the gastrojejunal stoma is made four cm. long by a Hoffmeister closure on the lesser curvature side of the residual gastric pouch. This operation was chosen because currently good results are being reported by a number of surgeons following distal hemigastrectomy (or antrectomy) and vagotomy^{1,2,7}. The advantages claimed for this operation are that it is followed by an extremely low incidence of recurrent ulceration, and a lower incidence of post-gastrectomy "dumping" syndrome.

The fourth operation chosen for comparison is a

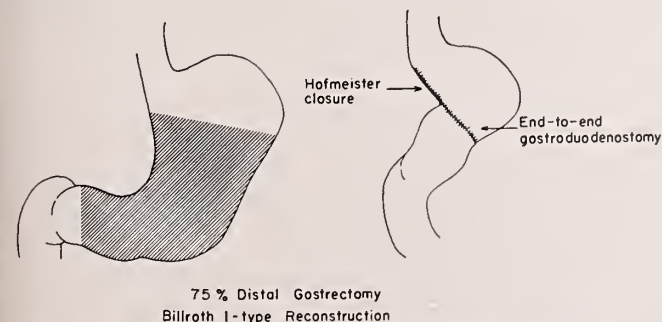


Figure 2: Seventy-five per cent gastrectomy, Billroth I-Type reconstruction.

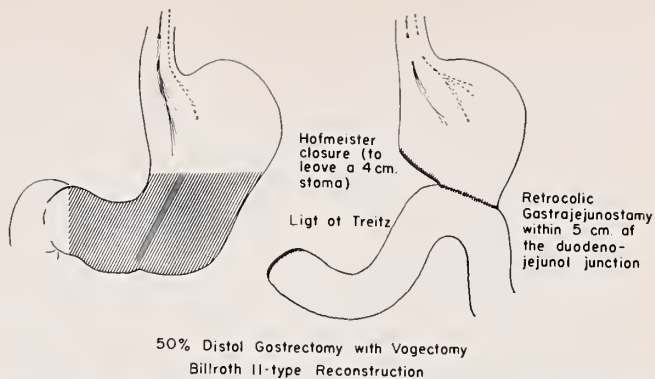


Figure 3: Fifty per cent distal gastrectomy with vagotomy, Billroth II-type reconstruction.

75 per cent segmental gastrectomy (Figure 4) in which the portion of the stomach between the antrum and fundus is removed, leaving a small residual proximal pouch consisting of the cardia and part of the fundus and a small distal pouch consisting of the antrum. An end-to-end anastomosis is made between the proximal and distal gastric pouches. One must do a pylorotomy with this operation because the vagal innervation of the pylorus and antrum is interrupted by the section of the stomach, and gastric outlet obstruction would otherwise result. This operation is advocated in the treatment of duodenal ulcer by Wangenstein^{10,11} who claims several advantages for it. It is said that it is applicable in the management of even the most difficult duodenal ulcer craters; that there is less "dumping" associated with it; a lower incidence of weight loss; better absorption of fat; and a very low incidence of recurrent ulceration.

Methods

The assignment of one of the four operations to a particular patient is made on the basis of chance. Every "staff" patient, in whom it is decided surgical treatment is indicated, is included in the study. Only after operation has been decided upon, and the patient is scheduled for surgery, is the type of operation he is to have determined. This is done by looking up his chart number in a table of random numbers and reading off the operation which corresponds to that number. In this way bias is eliminated in the selection of patients and operations. However, if a particular operation does not seem to be con-

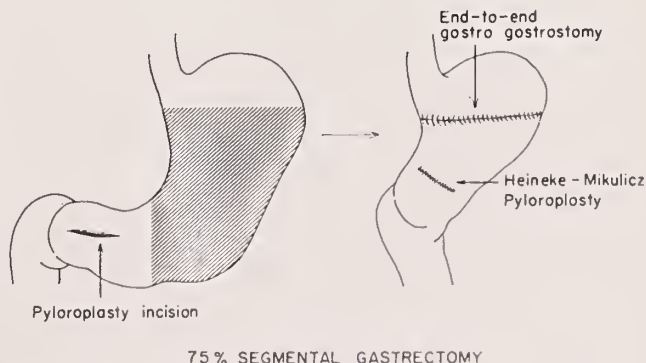


Figure 4: Seventy-five per cent segmental gastrectomy.

sistent with safe surgical practice at any time during the procedure, the surgeon may change the operation to fit existing conditions.

The techniques for performing the four operations have been agreed upon by the senior staff and standardized, so that comparable operations of any given type are performed in all patients. The chief residents are the surgeons in most of the operations but before they do the surgery on their own, they assist one of the senior staff members until they have become familiar with the technics, and then are assisted by them until the senior staff is satisfied that they will do the various operations in the prescribed manner.

The patients are followed routinely in the outpatient clinic, but for their definitive follow-up studies, they are readmitted to the hospital for a two-day period. They are admitted one afternoon and are interviewed and examined by a resident. The next morning they have blood drawn for a complete blood count, total and fractional serum proteins, and a serum cholesterol determination. They have a gastric analysis with histamine and an upper gastrointestinal X-ray study; the effect of a hypertonic test meal on their blood volume is measured by the radioactive chromium—tagged red blood cell method; and a specially trained technician helps them fill out a postgastrectomy study questionnaire.

Results

Only a relatively small number of patients in each group has been studied to date, so that any percentages reported herein have a little statistical significance. However, the results so far are interesting and deserve consideration. This report includes only patients who have been readmitted to the hospital for follow-up and who are 11 to 30 months post-gastrectomy. Meeting these requirements were 10 patients in the Billroth II group, 14 in the Billroth I group, 11 in Billroth II plus vagotomy group, and 10 in the segmental gastrectomy group. The results of the study are evaluated under a number of headings which are listed below.

1. *Patients Own Opinion of his Post-gastrectomy Status as Compared with his Pre-operative Status.*

There was no real difference among the various groups in this regard. About 80 per cent of the patients in all groups claimed that they definitely felt better following their operations. Only approximately 40 per cent would admit that they were stronger and 30 per cent claimed they were actually weaker. Only a single patient of the 45 studied felt that he could do more hard work and many said that they

could no longer do any hard work, mostly because they "played out too quick."

2. *Post - gastrectomy "Dumping" Syndrome.* "Dumping" syndrome symptoms are difficult to assess objectively. Almost all post-gastrectomy patients will admit, under close questioning, that they have a feeling of weakness, or tachycardia, or sweating after they drink milk or eat sweets at least once in a while. It was decided that, for purposes of comparison in this study, only patients who had "dumping" symptoms which caused them to lie down after meals regularly would be considered to have the "dumping" syndrome to a significant degree. With this as the criterion, nearly one-half of the patients in the Billroth I and Billroth II groups had significant "dumping" syndrome symptoms, while only about one-fourth of those in the Billroth II plus vagotomy and segmental gastrectomy groups had them.

It is well known from the reports of Roberts and her associates⁶ and others that there is a sudden decrease in circulating blood volume following oral administration of hypertonic glucose. This decrease in blood volume occurs during the time that the "dumping" symptoms occur, and it is thought to be the cause of many of the symptoms of the "dumping" syndrome.

Each patient in the present study had the changes in his blood volume resulting from an oral test dose of 200 ml. of 50 per cent glucose measured by the chromium—51 tagged red cell method. In sharp contrast to the differences noted in the incidence of "dumping" symptoms among the various groups, the changes in blood volume were essentially the same in all four groups. There was a sharp drop in blood volume during the first 20 minutes with a gradual rise to control levels during the next 60 minutes.

3. *Postprandial Vomiting.* In this study, postprandial vomiting seemed to be a problem separate from the "dumping" syndrome problem. It was an especially common complaint among the Billroth I patients. Vomiting occurred within 10 minutes after ingestion of the 200 ml. hypertonic glucose test meal in more than 50 per cent of the Billroth I patients and in 30 per cent of the segmental gastrectomy group. It occurred in only about 10 per cent of the other two groups.

If this trend toward an increased incidence of nausea and vomiting in the Billroth I and segmental gastrectomy groups continues as a more significant number of cases is accumulated, it may mean that there is a vomiting reflex trigger in the duodenum that is touched off by sudden filling of the duodenum. Since in the Billroth I and segmental gastrectomy the gastric content passes directly into and through

the duodenum and in the other two operations it does not.

4. *Diarrhea.* Diarrhea proved to be a problem in only one patient—a woman in the Billroth I group. She was also troubled by severe “dumping” syndrome symptoms.

Diarrhea has been frequently reported as a complication of vagotomy; however none of the patients in the Billroth II 50 per cent vagotomy series had this complaint.

5. *Weight Loss.* Any weight-loss of over 5.0 kg. was considered to be significant. With this as the criterion, approximately 20 per cent of all of the post-gastrectomy patients had lost a significant amount of weight. There was very little difference in the incidence of weight loss among the various groups.

6. *Anemia.* For purposes of comparison any patient who had a hemoglobin of less than 11.0 gm. per 100 ml. was considered anemic. Only three patients, one in the Billroth I group and two in the Billroth II group, were found to be anemic. There was no evidence of recent blood loss in these three patients, and there were no symptoms or X-ray findings suggestive of recurrent ulceration. One of these patients had rather severe “dumping” symptoms but the other two did not.

7. *Acidity of the Gastric Juice.* The average values for the free and total acid in the fasting state and the average of the maximum values with histamine stimulation are shown in Table I. Both Billroth II groups had low free acid values even with histamine, the Billroth I group had somewhat higher values, and the Segmental group had the highest. The differences in the total acid values among the various groups are somewhat less striking but are still quite evident.

TABLE I
Acidity of the Gastric Juice in Post-gastrectomy Patients Expressed in Clinical Units.
(Average of the value for all patients in each group.)

	FASTING		MAXIMUM WITH HISTAMINE	
	Free	Total	Free	Total
Billroth I 75%	. . . 0	15	13	32
Billroth II 75%	. . . 0	14	3	24
Billroth II 50% +				
Vagotomy	. . . 0	23	8	44
Segmental Gastrectomy				
75% 6	22	49	60

The significance of the free and total acid in the gastric juice of post-gastrectomy patients is not clear. Many are found to have no free hydrochloric acid in the gastric aspirate even after histamine stimulation. Yet we know that they still have a fairly

large residual segment of gastric mucosa capable of secreting a highly acid gastric juice, especially with histamine stimulation. It may well be that the specimen we obtain by aspiration, when it contains no free acid, is not pure gastric juice but a buffered neutralized mixture of gastric juice, succus entericus, pancreatic juice, and bile. This mixture may result because a widely patulous gastric outlet allows gastric juice to drain into the small bowel and be neutralized as it is formed or because the end of the sampling tube passes into the small bowel and mixture of gastric juice with alkaline juices occurs in the tube as the fluids are being aspirated. If this is true, the presence of free acid in the gastric juice of post-gastrectomy patients may not have the significance that is often attributed to it; patients may well have free acid in their gastric juice and still not be likely to develop recurrent ulcers.

8. *Recurrent Anastomotic Ulcers.* Five recurrent anastomotic ulcers have been detected in the 45 patients in this study so far. All were demonstrated on X-ray examination. One of these was in a woman in the Billroth II 50 per cent plus vagotomy group. This patient has severe rheumatoid arthritis and has been on prednisolone continuously for her arthritis, so that this can probably be considered to be a cortisone ulcer. The other four ulcers were found in the Billroth I group, giving a recurrence rate in this group of 29 per cent. It is interesting to note here that only two of these ulcers were suspected on the basis of symptomatology and physical examination. The other two patients were thought clinically to be having only a moderate degree of “dumping” symptoms until the results of their X-ray studies were reported. These two anastomotic ulcers were found only because routine X-ray studies were done as a part of the study. An occurrence like this might help to account for much of the discrepancy that exists in the literature as to the efficacy of the Billroth I operation in the treatment of peptic ulcer. For although some investigators are enthusiastic advocates of the Billroth I procedure, others hold that it is followed by a definitely greater incidence of recurrent ulceration than the Billroth II operation^{5,8,9}.

Summary

This is a description of the details of a study of various methods of treatment for peptic ulcer of the duodenum now being conducted at the Medical College of Georgia. An attempt is being made to compare objectively the results of four of the currently popular surgical procedures used in the treatment of duodenal ulcer. A preliminary report of the results to date has been presented but as yet there is not a sufficiently large number of cases in any of the series to give any statistically significant report of the results. With the information so far obtained however,

GASTRECTOMY / Brackney

it would seem that the least desirable of the four procedures under study is the Billroth I, since four out of 14 patients with this type procedure have had recurrent ulcers.

Talmadge Memorial Hospital

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HEKTOEN MEDAL

THE HEKTOEN GOLD MEDAL of the American Medical Association has been awarded to a team of surgeons from Tulane School of Medicine for the best scientific exhibit at the 108th annual meeting of the AMA in Atlantic City, New Jersey. The exhibit was on the perfusion treatment for cancer, a technique developed at Tulane, and won out over 387 other scientific exhibits. The award was presented by Dr. Oscar Creech,

Jr., professor of surgery and chairman of the department, Dr. Edward T. Krementz, associate professor of surgery, Dr. Keith Reemtsma, assistant professor of surgery, Dr. Robert F. Ryan, assistant professor of surgery, and Dr. James Winblad, instructor in surgery. Perfusion consists in circulating chemotherapeutic agents through an isolated organ or limb by means of an extracorporeal circuit.

SENIOR CITIZENS MEDICAL CARE

CALIFORNIA'S SENIOR CITIZENS are currently being offered the opportunity to enroll in a health plan specifically designed for them by California Physicians' Service, the Blue Shield Plan serving the entire state.

The new plan, called "MD-Plan 65," confines coverage to doctors' services, such as surgery and physician visits at the hospital, home or office. Limited X-ray and laboratory benefits are also provided. The plan is being offered on an experimental basis to all Californians 65 years of age and older during the month of June.

The special plan is the result of action taken by the California Medical Association last February, calling for "... California Physicians' Service to proceed with all speed to develop and actively sell voluntary health plans to further expedite the health care of the aging."

Physicians of the California Medical Association have approved a special lower schedule of fees in order to make the needed benefits to senior citizens available

at a reasonable cost. The California Blue Shield Plan's payment (based on these fees), plus a nominal co-payment by the member, will be accepted as full payment for contract benefits when a single member's income is \$3,000 a year, or \$4,500 a year for a married couple. The full payment feature applies to services rendered by the 14,000 California Blue Shield physician members only.

Monthly rates for the "MD-Plan 65" are \$6.90 a month for a man, \$7.90 a month for a woman.

In line with the new plan announced by California Physicians' Service, the National Association of Blue Shield Plans reports that almost all of the 65 Blue Shield Plans located in the United States are taking steps to provide programs for senior citizens. Twenty-one Blue Shield Plans, in addition to California Physicians' Service, have already announced that they are enrolling persons past 65 under special contracts designed for the aged.

LOW BACK PAIN

THOMAS P. GOODWYN, M.D., *Atlanta*

The tolerance of the individual patient for pain constitutes an important factor in the evaluation of his difficulty.

IN AN EFFORT to discuss low back pain it would seem advisable not to include any of the diseases which are commonly associated with the spine as a whole such as; arthritis, rheumatoid or degenerative, tuberculosis, Marie-Strumpell disease, neoplasm, etc., and confine ones self to those conditions peculiarly affecting the last three lumbar articulations.

The joint between the third and fourth vertebrae is infrequently the site of a disc lesion or a spondylolisthesis. The joints between fourth and fifth and the fifth lumbar vertebra and the sacrum are the more frequent locations of bone and joint and neurological pathology.

The quadruped spines taking off from the practically horizontal pelvises pass forward to receive support of the fore legs are not prone to many variations or malformation of its last two lumbar vertebrae and, so far I am able to tell, suffer very few disabilities in this area.

The human spine arising from the only partly tilted pelvis must reach the biped or upright position at expense of marked bending in the lower dorsal region. For the most part this bending takes place at the lumbosacral and the fourth and fifth lumbar articulation. The fifth lumbar is in midst of the greatest part of the curve and receives shearing stress both on its superior and inferior articular surfaces. The spine in this hyperlordotic position has caused the body of the fifth lumbar to grow thicker at its anterior than at its posterior portion. The fifth lumbar body is so situated in this curve as to occupy and some what resemble a keystone in an arch. However, the arch is in the reverse position

to give strength and only serves to weaken the arch in supporting the spine above the fifth lumbar level.

Fortunately, the articular facets of the first sacral segment face backward to articulate with the forward facing facets of the fifth lumbar which form a strong buttress to prevent any forward displacement of the fifth lumbar on the sacrum. The strong ligaments about the facets of apophyseal articulation add strength to this type of joint. The ligamentum flavum and the intraspinal ligaments and muscles still further re-enforce this joint to prevent any anterior displacement of the fifth on the sacrum.

Unfortunately, all fifth lumbar apophyseal articulations do not face anterior-posterior. Frequently they face oblique or more internal-external type and do not give the same strong bony buttress as the antero-posterior type. The variations may also be in one side facing internal-external and the other be oblique or anterior-posterior. The asymmetrical type facets on the same joint can and is the site of minor sprains or strains, as the motion at that level may be in line with its plane of motion of one apophyseal articulation and the same time at a right angle to movable range of the one on the opposite side.

Failure of the articular facets between the fifth lumbar and the first sacral segment to form a strong buttress can permit anterior displacement (spondylolisthesis) at this level.

Failure of the pedicles to form solid connection between the anterior and posterior elements of the fifth lumbar can permit anterior displacement at the lumbosacral level. These interior dislocations can be congenital or develop at any age up to late adulthood, when firm fibrous adhesions have probably developed. The degree of anterior slipping can vary from only a very slight amount which is hardly per-

Presented at the *105th Annual Session of the Medical Association of Georgia, May 17, 1959, Augusta, Georgia.

ceptible, to complete dislocation of the body of the fifth. The author has treated one patient 16 years of age in which the fifth lumbar was dislocated into the pelvis. The inferior articular surface of the fifth lumbar was rotated backward and was resting against the anterior surfaces of the first and second sacral vertebrae. Although the spine presented a very severe deformity from a lateral view and had a shelf-like deformity on the posterior view, she was attending school up until two days before she was sent to me. She was beginning to complain of some backache and to have some difficulty in walking to school which was several blocks away. In treating her, no attempt was made at correction before long grafts from the sacrum up to the upper dorsal spine. Additional iliac bone was used to supplement the grafts. Approximately one year later she resumed her classes while wearing a long steel and leather back brace. She was followed for several years and was doing satisfactorily.

Spondylolisthesis

Spondylolisthesis can occur between the fourth and fifth lumbar or less frequently between the third and fourth lumbar and the upper lumbar vertebrae.

The fifth lumbar vertebra may have an anomalous enlargement of a transverse process which grows out straight to form a joint between it and the ilium which may restrict motion between these two bones and at the lumbosacral articulation.

There is a much more frequent outgrowth of the transverse process of the fifth lumbar vertebra in which the process may turn downward and fuse with the sacrum or join with the latter through a semi-movable joint. When this condition exists on one side only, it can be a source of pain from injuries while bending or making sudden or awkward motions.

When this later type of deformity of the transverse occurs bilaterally, there is so much restriction of movement between the fifth lumbar and the sacrum that practically all movements shift upward and the lumbar four-five joint takes on the function normally carried on by the lumbosacral articulation.

There is a fairly frequent low back complication due to the posterior arc of the vertebrae made up of the laminae and spinous process being congenitally separated from the pedicles on either side. This free portion of the spine is so movable that in some cases the spinous process can be felt to move under the fingers in making the physical examination. There seems to be a wide divergence of opinion as to whether the loose fragment should be removed alone or removed and a graft placed from the vertebra

above to the vertebra below or simply to do nothing in the way of surgery.

The joints of the spine are subject to strains, sprains, or inflammatory reactions just as the large joints of the extremities. In the same manner any painful joint is liable to be restricted in its normal range of motion by the inflamed and tight muscles (muscle spasm) and local soreness to touch or pressure. In normal bending of the spine some motion should take place at each joint level giving a full regular curve similar to a chain bending at each link when supported horizontally between two points. Local restricted motion at one or more joints is about the surest of all signs of a localized injured or sick vertebra or vertebral articulation. This muscle spasm or rigidity is involuntary and is hard to duplicate by voluntary action on the part of the patient. Any attempt to fake this involuntary muscle spasm can usually be very quickly detected by repeating the movement several times and also by watching the patient's movements while stepping in or out of his clothes, getting on or off the examining table, and in many other ways. A patient may have difficulty in getting on or off an examining table and have no difficulty whatsoever in climbing on and off an X-ray table in an adjoining room when he lets down his guard. It is customary to have the patient bend forward with both arms reaching for the floor with head tilting forward and flexing the neck. The spine is watched carefully for any restriction as the patient flexes, raises to perpendicular, and bends backward the full range. Very often extreme extension is painful at the lumbosacral junction, from many types of injuries.

Lateral Bending

Lateral bending to the right and left while the knees are kept extended is very likely to show muscle spasm and restricted motion if there is much of an injury or disability present. This lateral restriction is usually constant in repeat bendings when true pathology is present.

Twisting or rotatory motions may be of some value but usually not as significant as lateral restriction.

When back pain is limited to the spine or radiation outward in one or both sides but without sciatic radiation the outlook is usually good for recovery, in the space of three to ten days under the usual rest, heat relaxants, and possibly traction, unless the patient for some reason does not desire to cooperate.

Patients with many areas of soreness or one with low back pain radiating upward or to the head should be looked on with suspicion.

Whenever, a patient gives a history of repeated attacks of low back pain usually getting more severe

and with shortening of intervals between attacks or who has had a recent severe back injury, one should suspect a disc lesion. The classical disc injury patient, usually gives an account of a low back sprain while lifting a heavy object, or lifting a less heavy object while the body was in a strained or awkward position. Frequently the history of two or more people lifting a heavy object and too much weight is suddenly thrown on one person with resulting back sprain or strain. If following such an injury the patient has unilateral muscle spasm over the lower lumbar muscles with sciatic radiation out into the buttocks, along posterior-lateral surface of the thigh, to the knee or down into the lateral side of the foot, the diagnosis is usually that of a ruptured disc. Pain on coughing or sneezing with a positive straight leg raising test and diminished or absent ankle re-

flex about clinches the diagnosis from physical examination of a herniated nucleus pulposa.

The introduction of opaque media and fluroscopic and X-ray plates can further demonstrate the presence, size, and location of the disc before treatment is undertaken or surgery contemplated.

If one desires more information concerning the status of the nucleus pulposa, the intervertebral joint can be injected with opaque material and make discograms.

In evaluating the cause of pain in any low back disorder the patient should be closely observed as to his tolerance for pain, as this can vary greatly in different individuals. It is also very important to know the underlying reasons for the examination and by whom the examination was requested.

478 Peachtree Street, N.E.

BRAWNER'S SANITARIUM

BRAWNER'S SANITARIUM AT SMYRNA has recently been informed that they have been fully approved by the Central Inspection Board of the American Psychiatric Association. This is one of the first psychiatric hospitals to be recognized by the Central Inspection Board. This will also entitle Brawner's Sanitarium to be approved

by the Joint Committee on Accrediation.

Brawner's Sanitarium has also received an award for a perfect record for 1958 in Group 1 of the Hospital Section of the safety contest, sponsored jointly by the American Hospital Association and the National Safety Council.

1959 CALENDAR OF MEETINGS

State

- Sept. 11-12—Georgia Heart Association, Savannah.
- Sept. 18-19—Georgia Tuberculosis Association, Athens.
- Sept. 18-19—Georgia Trudeau Society, Athens.
- Sept. 20—Georgia Psychiatric Association.
- Sept. 24-26—Georgia Chapter, American College of Surgeons, Sea Island.
- Oct. 9-10—Grady Hospital Clinical Society, Atlanta.

Regional

- Sept. 28-29—Tennessee Valley Medical Assembly, Chattanooga, Tenn.
- Oct. 16-18—The Potomac-Shenandoah Valley Post-Graduate Institute, Shenandoah Hotel, Martinsburg, W. Va.
- Nov. 16-19—Southern Medical Association, Atlanta.

National

- Aug. 30—American Congress of Physical Medicine and Rehabilitation, Minneapolis, Minn.
- Sept. 27 - Oct. 2—American College of Surgeons, Atlantic City, N. J.
- Sept. 13-17—International College of Surgeons, Chicago, Ill.
- Oct. 3-8—American Academy of Pediatrics, Chicago, Ill.
- Oct. 10—American Rhinologic Society, Belmont Hotel, Chicago, Ill.
- Oct. 15-17—The Academy of Psychosomatic Medicine, Sheraton-Cleveland Hotel, Cleveland, Ohio.
- Oct. 23-25—American Heart Association, Philadelphia, Penn.
- Nov. 29-Dec. 2—National Society for Crippled Children and Adults, Chicago, Ill.

OCULAR SIGNS OF DIABETES

Familiarity with the use of the ophthalmoscope can be very helpful in the management of diabetes.

JOHN R. FAIR, M.D., *Augusta*

VASCULAR CHANGES ARE among the most important in diabetes mellitus of long standing. In the eye, we have an unusual opportunity to observe the state of the blood vessels. It is not surprising then, that ophthalmoscopic examination has come to be an important aid in the diagnosis and management of diabetes.

In a way, the ocular complications of diabetes are a tribute to the success of modern treatment methods since many years of life are required for their development. Prior to the introduction of insulin, diabetics simply did not live long enough to experience the vascular degeneration that accounts for the well known retinopathy, the cataracts, and the neuropathy that characterize the late stages of the disease.

In considering the eye signs of diabetes, one thinks ordinarily only of diabetic retinopathy because of its diagnostic and prognostic value but other changes are common enough to make their enumeration worthwhile. It is the purpose of this paper to describe the various stages of diabetic retinopathy and to list the other common ocular complications that occur. No special attempt will be made to explain or theorize on the subject. Instead, it is hoped that this brief written description and the accompanying illustrations will enable the clinician to recognize and manage the eye problems of his diabetic patient.

Diabetic Retinopathy

The basic pathologic process responsible for diabetic retinopathy manifests itself in a tendency to-

ward new blood vessel formation and hemorrhage. The idea that the retinal capillary microaneurysm is the source of all the retinal changes that occur is probably an oversimplification of the matter. Microaneurysms probably do rupture and bleed but there seems to be some other more widespread stimulus to new blood vessel formation. Tufts of small vessels are seen to blossom out over relatively large areas of the retina in the absence of a previous hemorrhage suggesting attempts at revascularization following deprivation of original blood supply. At any rate, it is these new formed vessels that produce the large hemorrhages that finally break through into the vitreous gel obliterating vision and setting the stage for retinal detachment.

Retinopathy is not seen except in cases of diabetes of long standing. At least 10 years of the disease are required for production of the vascular phenomena. Diabetics who acquire their disorder in childhood are especially likely to experience visual difficulty. The earliest change is the appearance of very small dark red or purplish, smoothly rounded dots in and about the central area of the retina. The retinal lesions of diabetes are grouped characteristically at what is called the posterior pole of the eye—that is, the region of the nerve head and macula. The purplish dots have been shown to be small aneurysmal dilatations of the capillaries on the venous side of the capillary system. Microaneurysms are too small to photograph and so can be described only verbally. Ophthalmoscopically, they are difficult to distinguish from the small, round, lighter red in color retinal hemorrhages that appear at about the same time in the same areas.

At this same early stage, small white spots may be seen in the macula or close to the disc. These have a "hard" look and characteristically are arranged in

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From the Division of Ophthalmology, Department of Surgery, Medical College of Georgia. Portions of this study were supported by a grant from the Knights Templar Eye Foundation.

a circular fashion in the macular region (Figures 1a and 1b) or about the nerve head (circinate retinopathy).

The small hemorrhages of diabetes take place in the deeper layers of the retina where they are more

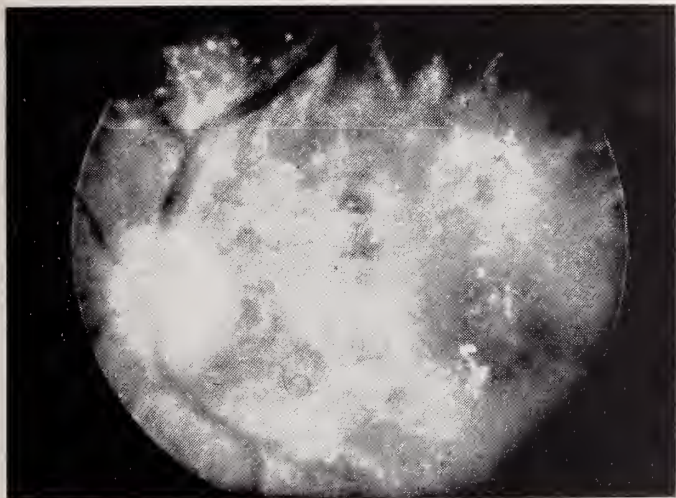


Figure 1 a.

or less contained and assume a circular or punctate shape (Figure 1c). These are easily distinguished from the superficial flame shaped hemorrhages of hypertensive retinopathy which spread lengthwise in the nerve fiber layer of the inner retina (Figure 1d).

None of the changes described so far interfere with vision. In more severe cases, newly formed blood vessels appear on the surface of the retina along with crescent shaped, veil-like whitish bands of connective tissue, the retinitis proliferans of diabetes (Figures 2a and 2b).

Finally, repeated larger retinal hemorrhages take place and eventually these break through into the clear vitreous gel (Figure 2c). Vitreous hemorrhages tend to resorb and vision improve so that one is inclined to credit whatever treatment is being used with the improvement that occurs. The natural remissions and exacerbations must be remembered in judging any new method of treatment.

Hemorrhage into the vitreous is followed by or-



Figure 1 b.

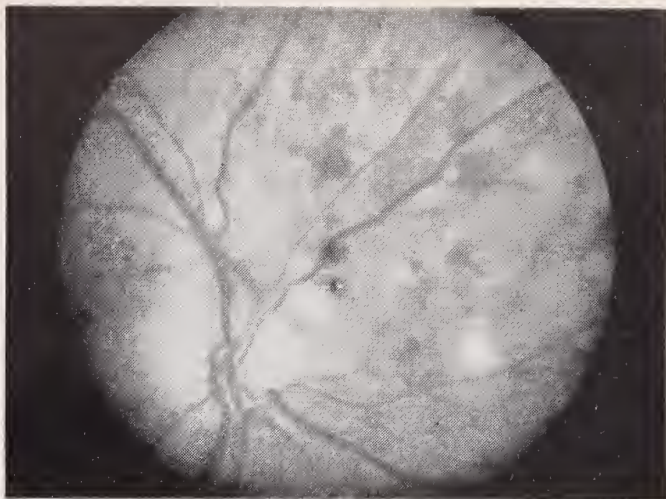


Figure 1 c.

ganization of unresorbed blood. Vascularized bands of scar proliferate into and across the vitreous chamber (Figure 2d). These contract to pull the retina away from its attachments bringing about final complete loss of vision.

The various stages of diabetic retinopathy require years for their development. There is some evidence indicating that the more rigid the control of the diabetes, the slower the appearance and progression of the retinal disease.

Numerous studies involving large series of cases have shown that advanced diabetic retinopathy is a good indication of renal damage¹. Practically all cases that have progressed to the point of kidney failure show retinal changes also.

In this connection, it has been suggested² that the retinopathy seen after the development of intercapillary glomerulosclerosis is no longer a pure diabetic retinopathy, the elements of hypertension and arteriosclerosis having been added.

Other Ocular Changes in Diabetes

Certain other eye ailments are prone to occur in

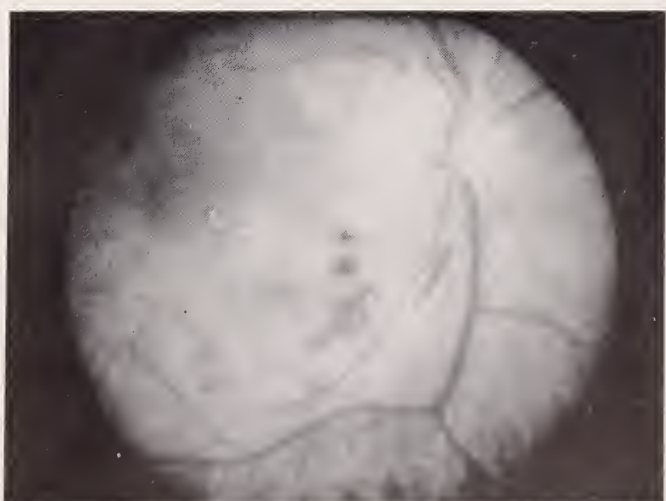


Figure 1 d.

Figure 1: Retinopathy of diabetes. The typical hard white exudates are shown in a and b. Round diabetic hemorrhages in c may be compared with the flame shaped hemorrhages of hypertension shown in d.

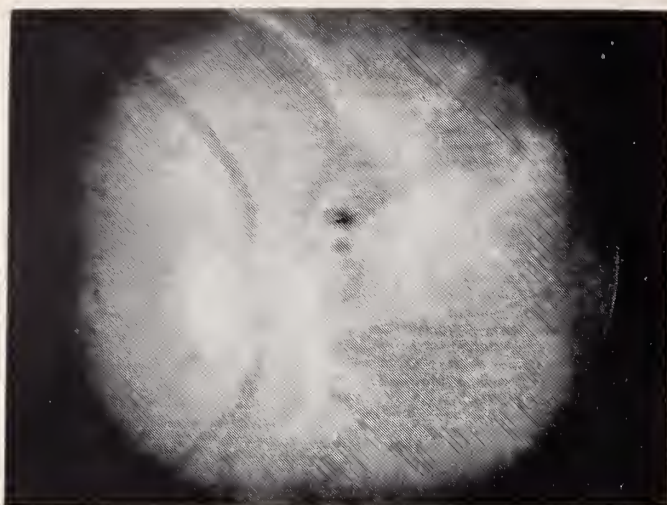


Figure 2 a.

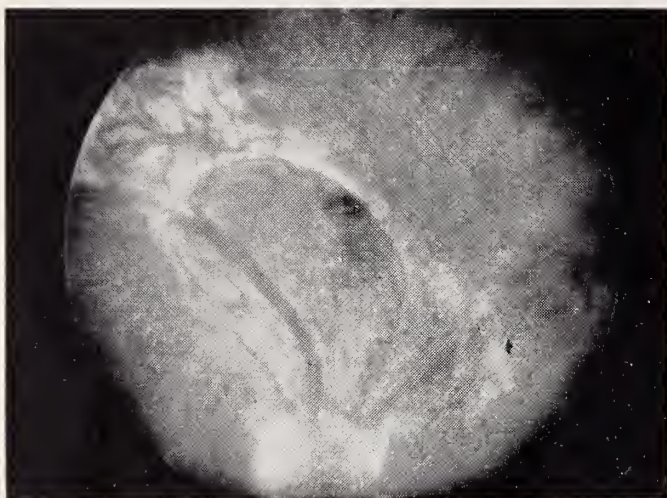


Figure 2 b.

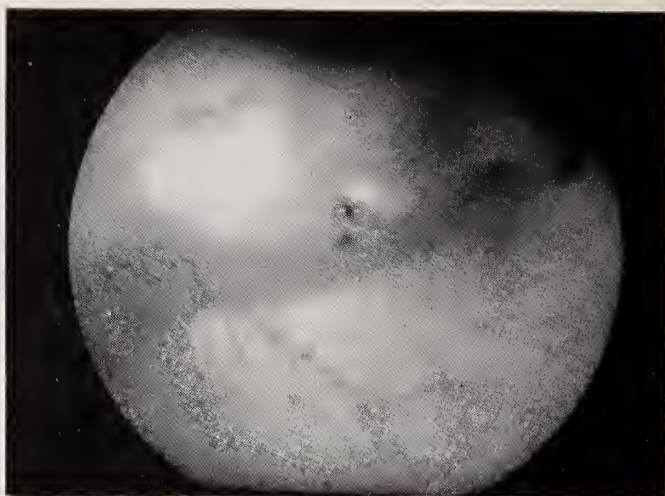


Figure 2 c.

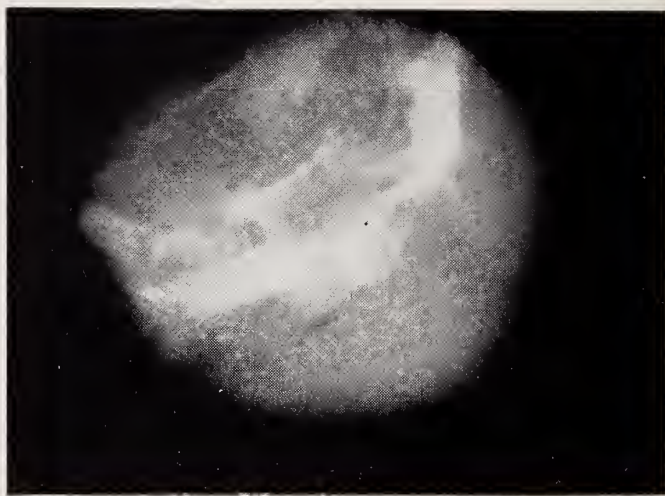


Figure 2 d.

Figure 2: Retinopathy of diabetes. In advanced cases, vascularized bands of scar appear on the surface of the retina as in a and b. Hemorrhage into the vitreous (c) leads to fibrous traction bands (d) and retinal detachment.

diabetes. Cataract is the most frequent and best known of these. The cataract of diabetes (Figure 3) is no more difficult to deal with than is the usual senile cataract from which it is indistinguishable. Visual results should be good following lens extraction providing that the retina is in good condition.

New blood vessels may form on the surface of the iris in cases of severe diabetes of long standing

(rubeosis irides, Figure 4). Spontaneous rupture of these vessels is seen occasionally, the anterior chamber filling partially or completely with blood (Figure 5). Secondary glaucoma may follow with loss of any sight that remains or even loss of the eyeball.

Diabetic neuropathy of the nerves to the ocular

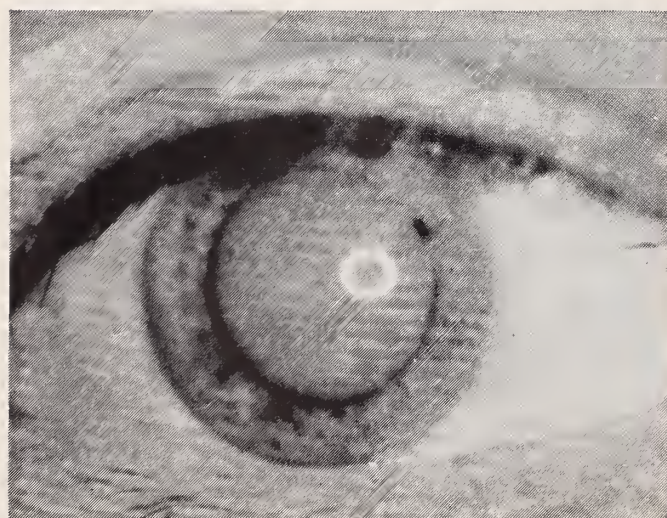


Figure 3: Senile type cataract so common in diabetes.

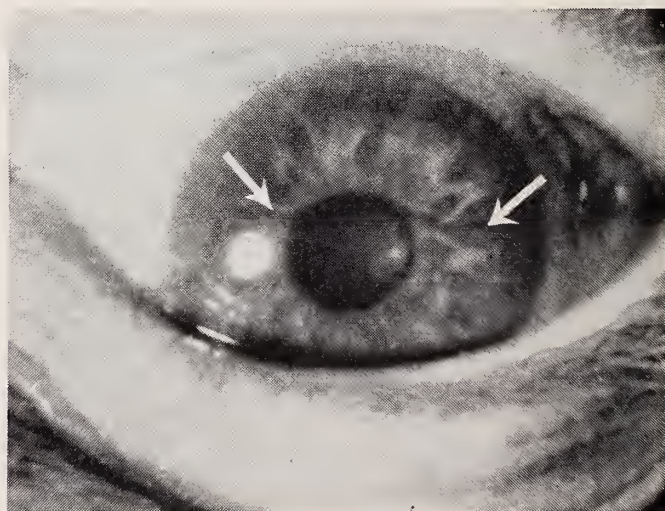


Figure 4: New blood vessel formation on the iris (rubeosis irides) as seen in diabetes.



Figure 5: Spontaneous anterior chamber hemorrhage in a diabetic. The arrow indicates the level of the blood.

muscles is a well known entity. Usually the third (Figure 6) or the sixth nerves are involved. Pain may be considerable simulating ruptured aneurysm of the Circle of Willis. Double vision is a problem when the sixth nerve is affected and in incomplete third nerve palsies in which the eyelid is not ptosed.

In general, arteriosclerotic changes in the eye are accelerated in diabetes. Occlusions of the central retinal artery and thrombosis of the retinal veins are more common than in non-diabetics of the same age groups. Ophthalmoscopic examination of older diabetics reveals the sclerosis of vessel walls that is going on in other parts of the body.

Diabetes is only one of the many systemic diseases in which ocular changes feature prominently.



Figure 6: Ocular muscle palsies may occur in diabetes. In the case shown, the third never is paralyzed, the affected eye turning down and out.

Familiarity with the use of the ophthalmoscope and time taken to examine carefully the outer eye will often clarify diagnostic problems for the general practitioner and specialist alike.

Summary

The various stages of diabetic retinopathy are described by means of fundus photographs and other common ocular complications of diabetes listed.

Medical College of Georgia

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STUDENTS TO ATTEND AMERICAN COLLEGE OF SURGEONS MEETING

MEDICAL STUDENTS FROM 36 medical colleges will attend the annual Clinical Congress of the American College of Surgeons as guests of the College.

The 45th annual Clinical Congress, world's largest meeting of surgeons, will be held this year in Atlantic City, New Jersey, September 28 - October 2, 1959.

The student participation program was initiated as an educational contribution of the College, by action of the Board of Regents. Students are selected by vote of their classmates, and medical colleges sending representatives to the Congresses are rotated.

The Regents of the College believe that the indoctrination of the physician in responsibility to patients

should be begun early in his training; and that one means to this end is an opportunity to attend meetings at which important scientific papers are presented by eminent men who typify the ideals of medicine.

Under supervision, the students will attend a number of special sessions in addition to regularly scheduled lectures, discussions, motion picture demonstrations, and televised clinics covering all phases of surgical practice and research.

Students from Georgia will be Richard A. Harde- man from Emory University School of Medicine and Henry Alfred Wilkinson, III from the Medical Col- lege of Georgia.

THE EMBLEM OF THE AMERICAN MEDICAL ASSOCIATION

GEORGE M. FISTER, M.D., *Ogden, Utah*
and
THOMAS A. HENDRICKS, *Chicago, Illinois*

THE GODS OF MYTHOLOGY, Mercury, Aesculapius, Zeus, Pluto, and others probably will shudder in their retreats to find another human writing about the caduceus. Many humans probably will be equally amazed at this attempt to clarify a confusion that has developed out of the simplicity of the gods' intentions.

The gods' intentions were probably very clear, but between the ancient Greeks, the slightly less ancient Romans, and modern physicians there has developed ambiguity and uncertainty about the emblem of medicine.

By definition the word caduceus is a Latin adaptation from the Greek, a herald's wand (*kerykeion*), so the only meaning that the word caduceus has is a herald's wand. It has no connection with and carries no implication as a symbol of medicine. The herald who carried the wand (the caduceus) was the Greek god Hermes, also referred to as Mercury by the Romans.

Now Hermes was quite a god of classical mythology. He was a messenger, a herald of assemblies, the patron of commerce and peace, god of the rogues, and was undoubtedly a clever thief and could roll a wicked game of dice. It would seem that he didn't have enough to do, so he was further assigned the duty of conductor of the souls of the dead to the infernal regions. Hermes was no doubt as fluid and as slippery as the metal called mercury.

It was clear that no herald could function without a wand; to do so would have been as impractical as a chairman without a gavel. So Hermes im-

mediately secured for himself a straight piece of an olive tree branch which was used as his wand. Thus the herald's wand, or caduceus, became one of Hermes' sacred possessions and he was apparently seldom seen without it.

The transition from the simple herald's wand to the more elaborate one with two snakes entwined was probably a gradual process, the addition of the snakes having been inspired by various legends plus the artists' interpretations. One legend relates that Hermes found two snakes fighting with each other. Hermes separated them with his olive branch wand, and by his kindness and the snakes' appreciation, they entwined themselves on his wand. Since Hermes was the messenger of the gods, two wings were added to the wand. These perhaps were to give him an increase in speed as he carried messages between friends and enemies. Thus, Hermes, with the caduceus, became an emblem of commerce and perhaps neutrality.

A review of the literature permits and sustains the conclusion that the caduceus was simply the herald's wand of the winged god Hermes and was (and still should be) an emblem of all of his numerous duties, which did not include medicine.

According to Arnold¹ "All the meanings that we might attach to the caduceus can be summed up into one: vis; that it symbolizes the peaceful condition of business—the mercantile world as opposed to the military." Nevertheless, the U. S. Army Medical Corps and the U. S. Public Health Service continue to use the emblem of Hermes as their insignia. Probably its use here is justified, the intent being to portray the noncombatant character of the Medical Corps rather than as an emblem of the medical profession. In addition, the name caduceus is used

Dr. Fister is a member of the Board of Trustees of the American Medical Association. Mr. Hendricks is Assistant to the Vice-President of the American Medical Association.

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almost universally, except in England, France, and Germany, as the emblem of the medical profession, an error that seems impossible of correction, but one that merits our best efforts to correct.

What then is the true emblem of the American Medical Association? Mythology relates that the Greek god Asklepios (Roman Aesculapius)² "studied the healing art and soon surpassed his teacher (Chiron) for his patients never died and he even succeeded in recalling the dead." Thus Asklepios was recognized by the Greeks as the god of medicine. Up to this point there is no apparent confusion between the two, Hermes and Asklepios, but for professional reasons Hermes carried a wand and Asklepios carried a staff and each began association with snakes. Complication of the significance of the symbols was the immediate result.

It is quite likely that Hermes and Asklepios sensing the need for a cane or walking stick, each unknown to the other, picked up a branch. Hermes made a straight olive wand, while Asklepios, being a little more rugged, made a knotty pine staff. Then along came the serpent! Like any physician, Asklepios was satisfied with and perhaps could afford only one, but Hermes, trained in the ways of commerce, sought out two snakes. The snakes in each case followed their natural instincts and entwined themselves about the sticks, one on Asklepios' staff and two on Hermes' wand.

Thus we have two symbols, the caduceus, a wand entwined with two serpents, and the staff of Asklepios, entwined with one serpent. Asklepios was recognized by the Greeks as god of medicine. His fame spread throughout the Mediterranean area and he is reported to have many medical sanctuaries, one of them in Epidaurus near Athens. Medical therapy in the era of Asklepiian temple healing, extending into the third century A.D., must have been impressive if not always curative for Asklepios is reported to have had a large following, what we would now refer to as a successful practice.

Of course Asklepios, the Greek physician, did not wear a stethoscope, but he was always seen with his heavy staff. After his death he was worshiped as a god by the Greeks and Romans. Mythology relates the origin of his birth, and his death was the result of Pluto's jealousy, who had Jupiter destroy him with a thunder bolt, which seems to be a noisy way the ancients had of removing any competition. Many shrines were built in honor of Asklepios, the god of health, where was carried on a special type of healing by incubation.

Serpents since the time of Adam have been regarded with both fear and admiration. The snake's annual renewal of its skin, the graceful movements, its speed and destruction of its prey gradually led

to sacred fascination and worship. To the snake was attributed rejuvenation, convalescence, wisdom, and long life. The serpents soon participated in certain rituals that were a definite part of the healing and curative procedures in the Asklepiian temples. In recognition the staff of Asklepios became adorned with a serpent, a symbol of the medical profession.³ "Reproduction of the statues of Asklepios usually show the physician standing in flowing toga with his right hand clasping the staff, along which a single snake makes its way upward." There need be no uncertainty about who is the mythical Greek and Roman god of the art of medicine. All legends, documents, and statues point definitely to Asklepios.

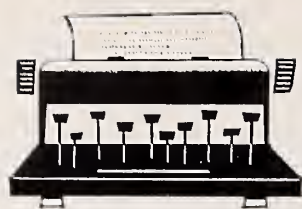
The American Medical Association in 1910 by official action of the House of Delegates adopted a report by a committee that had been appointed to revise the emblem of the Association. The Committee stated "The true ancestral symbol of the healing art is the knotty pine and the serpent of Asklepios. That the color of the new emblem should be scarlet and gold and the new emblem should be the knotty rod entwined with the serpent."⁴ Much credit is due the Committee that was assigned to this task.

In retrospect of the error and looking forward to its correction, the following summation is presented:

1. The word caduceus means a herald's wand. It is a straight wand entwined with two serpents. It is not an emblem of the medical profession (although it has been adopted by medical and lay organizations).
2. Asklepios was a medical deity or legendary physician and he was enshrined as the mythical god of medicine.
3. The emblem of the American Medical Association is the knotty staff of Asklepios, entwined with one serpent. This is not a caduceus and should not be confused with one or referred to as one.
4. The American Medical Association should conduct an educational program to correct the grossly negligent use of the word caduceus. State, county, and local medical societies should assist the program. All physicians should be made acquainted with the emblem of the American Medical Association, which is the staff of Asklepios (Roman Aesculapius).

References

1. Arnold, H. L., Jr.: Serpent—Emblems of Medicine, *J. Michigan M. Soc.* 36:157-168 (March) 1937; Fielding H. Garrison, the Caduceus and the United States Army Medical Department, *Bull. Hist. Med.* 13:627-630 (May) 1943.
2. Veith, I.: Symbol of Medicine: Caduceus of Hermes or Knotted Staff of Aesculapius? 26:138-148 (July 15) 1958. Zwick, K. G.: Origin and Significance of Medical Emblem, *Bull. Soc. M. History, Chicago* 4:94-105 (April) 1928. Bremer, L. J.: Caduceus Again, *New England J. Med.* 258:334-336 (Feb. 13) 1958. Tobey, J. A.: Magic Wands of Medicine, *Hygeia* 8:348-350 (April) 1930.
3. Stenn, F.: Personal communication to the author.
4. Transactions of the House of Delegates of the American Medical Association June, 1909. pp. 39-40; June, 1910, pp. 34, 46.



editorials

Health Care of the Aged

DR. WILMA DONAHUE, of the division of gerontology, University of Michigan, has stated that age is getting to be as popular as sex. Greater emphasis is being placed on the study of the aging process in this country from the medical, social, economic, and research standpoint.

In September 1958 the Fogarty Bill became law. Congress authorized and appropriated funds to set up state wide surveys to study the problems of our Senior Citizens. This data, in turn, will be correlated and presented at a White House Conference on Aging in January, 1961.

Our own President of the Medical Association of Georgia created a new committee on aging to include the chairmen of all standing committees of the association wherein the health care of the aging was concerned. These include the following committees:

Geriatrics, Hospital Relations, Industrial Health, Insurance & Economics, Legislation, Mental Health, Public Health, Rural Health, Public Service, and Rehabilitation.

Soon thereafter, the American Medical Association, American Dental Association, American Hospital Association, and the American Nursing Homes Association joined the forces to support the newly organized Joint Council to Improve the Health Care of the Aged. Appointed representatives of all States and Territories met together in Washington, D. C. following the Annual Session of the American Medical Association. From this beginning, our own Medical Association of Georgia joined together with

the Georgia Hospital Association, Georgia Dental Association, and the Georgia Nursing Home Association to form a separate Joint Council at a state level. By general agreement, the objectives of the Georgia Joint Council were as follows:

- (1) Representation and active participation in the Governor's Commission on Aging;
- (2) Identifying and itemizing the health needs of the aged in Georgia;
- (3) Appraising available health resources in Georgia;
- (4) Fostering effective methods of payment for health care;
- (5) Developing community programs;
- (6) Fostering health education programs; and
- (7) Informing the public of the facts related to health care of the aged.

Representatives of the Medical Association of Georgia and the newly formed Georgia Joint Council have conferred with the Honorable S. Ernest Vandiver, Governor of Georgia, early in July. A suggested plan for conducting a survey of this overall aging problem was presented and discussed with the Governor. The cooperative willingness of all organizations involved was pledged. The deep desire of the physicians of Georgia to participate actively was made known. By surveying the needs, exploring the possible solutions, and applying these solutions in a practical manner, it is hoped that the goal of optimum health for every citizen of Georgia may be achieved.

John S. Atwater, M.D.

Indoctrination of New Members in Fulton

ELECTION TO MEMBERSHIP in a county medical society represents an important milestone in the life of a young physician. Many societies honor this noteworthy event with a formal or informal initiation ceremony, but few provide an information course to indoctrinate new members.

The benefits and values to be derived from organized medicine must be advertised to those starting down the pathway to successful medical practice. By acquainting new members with the medical organization, its services and functions, the active members can demonstrate the democratic manner in which medical societies operate. New members must be accepted in more than a casual manner, if their subsequent active participation is desired. Lack of interest in the medical society may begin and continue because of a too casual manner in election to membership. A strong medical society is one in which each member participates with enthusiasm. Proper indoctrination can set the stage for such interest.

The hospitality and indoctrination committee of the Fulton County Medical Society welcomes, entertains and instructs new active members at social-informational gatherings at a local club several times each year. These are held at intervals dictated by the number of available new members. Present at these functions, in addition to new members, are members of the committee and certain officers of the society. A ratio of one active member for each neophyte is maintained. In addition to the major officers, the secretarial staff and public relations counsel

of the county medical society are invited. The Medical Association of Georgia is represented by one of the executive secretaries, and the American Medical Association, by a delegate. Informal indoctrination talks are given and discussed, sufficient talent being present to answer questions about organized and unorganized medical topics. Informality is stressed. The benefits, values, and obligations of organized medicine are discussed. Topics include society history, ethics, medical economics, legislation, organization of the county medical society, mediation committees, group insurance, judicial council activities, public relations, and other related subjects. Leaflets and brochures are distributed as available.

It is amazing to observe the eagerness new members exhibit, and their questions often stimulate extended discussions on subject matter not prepared in advance. Able active members must be in attendance to provide the correct answers.

Limited experience has demonstrated the importance of indoctrination of new members. The informal combination of a social meeting and an indoctrination course has satisfied the immediate needs of the Fulton County Medical Society. The hope is to strengthen the medical society by stimulating each new member to participate with enthusiasm. If the society fails in this lofty objective, it will have at least shown the new member that the society is interested in him. He will thereafter recognize the fact that organized medicine, while dedicated to the service and welfare of mankind, also serves the physician.

J. Frank Walker, M.D.

NEW PAMPHLET ON TUBERCULOSIS

THIS PAMPHLET has been produced by the Georgia Tuberculosis Association with Christmas Seal money. Its purpose is to answer some frequently asked questions about tuberculosis, to define Georgia's tuberculosis problem, and to explain the facilities and resources

available for tuberculosis control in Georgia.

The pamphlet is free. Orders should be placed through the local Tuberculosis Association or the Georgia Tuberculosis Association.



THE USE OF ANTICOAGULANT DRUGS IN THE TREATMENT OF CEREBRAL THROMBOSIS

HERBERT R. KARP, M.D., *Atlanta*

THE STEADILY MOUNTING rate of occlusive disease of the cerebral arteries has incited intensive studies of methods of treatment of this all too often devastating clinical state. Since in the majority of instances these occlusions occur against a background of atherosclerosis and hypertension, the ultimate goal is prophylaxis by which it will be possible to modify or prevent the development of these two inciting factors. Such an approach remains outside our grasp at present, however. Accordingly, clinicians have turned to virtually any form of therapy which offers a reasonable chance to modify the effects of occlusion of cerebral vessels on the parenchyma of the central nervous system. Prominent among these therapeutic efforts has been the use of various forms of anticoagulants.

An extensive controlled study to evaluate the efficacy of anticoagulants in occlusive cerebrovascular disease is now in progress at seven medical schools in the United States. The task is a difficult one largely because we are attempting to evaluate the effectiveness of a therapeutic maneuver in a disease whose natural history has not yet been fully delineated.

The study thus far has fairly definitely indicated that anticoagulants are of no benefit in the accomplished cerebral infarction. Hence, it becomes important to direct this form of therapy at limiting the

stroke which has not yet reached its full extent or more important, the prevention of the stroke which has not yet occurred. Cerebral embolus occurs with such rapidity that one does not have the opportunity to modify its course. On the other hand, the development of an atherosclerotic occlusion is preceded by various forms of prodromata or warnings in 70 to 80 per cent of cases. These warnings may take the form of progression in which components of the final infarction are accumulated in a stepwise fashion, the so-called thrombosis-in-evolution. In others, the final stroke is often heralded by many ischemic attacks in the form of transient episodes of neurologic dysfunction which usually clear without residua. It is during these prodromal phases that the use of anticoagulants stands to be of most benefit. Therefore, the most important facet of the intelligent use of anticoagulants is the recognition of the early phases of cerebral thrombosis.

Transient ischemic attacks most frequently are encountered in the days or weeks preceding the thrombotic stroke. They are seen in association with thrombosis of virtually any of the superficial or deep cerebral vessels; e.g., the internal carotids, the vertebrals, the basilar, the middle cerebral, the anterior cerebral or the small penetrating arteries to the basal ganglia or the midline deep structures of the brain stem. As a generalization, transient ischemic attacks

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

are more frequent in the vertebral basilar system than in the carotid vessels. The clinical manifestations are, of course, a function of the vessel involved. In the carotid system (i.e., the carotid artery, the anterior cerebral and the middle cerebral arteries) the episodes commonly take the form of unilateral sensory and/or motor deficits of the side of the body opposite the lesion. When the hemisphere dominant for speech is involved, one frequently encounters aphasia. The patient may report transient monocular blindness on the same side as the lesion, this being pathognomonic of involvement of the homolateral internal carotid artery. In the vertebral basilar system the attacks are frequently more difficult to characterize. In general, however, bilateral weakness and/or numbness, involvement of one or more cranial nerve structures at a nuclear level, diplopia, whirling dizziness or loss of consciousness speak for involvement in this system.

It is to be emphasized that the features of the ischemic attacks are most frequently fragments borrowed from the stroke which experience has taught us is often to follow. Examination of the

patient during the early stages most frequently reveals little if any neurologic deficit. Therefore, the proper interpretation of the history is of paramount importance.

In summary, preliminary observations indicate that anticoagulants are probably effective in reducing the number of transient ischemic attacks as well as in halting or slowing down the stepwise progressive course in cerebral thrombosis. These observations make it imperative that the clinician be aware of the clinical features of the prodromal phases of the cerebral thrombosis seen before the full development of the cerebral infarct. Particular attention should be given to transient ischemic attacks as well as cerebral thrombosis-in-evolution. Though effective, the use of the anticoagulant drugs is fraught with many dangers and should be administered only after careful evaluation of the patient. Long-term anticoagulation should be undertaken only in situations where close and frequent follow-up is possible in conjunction with a reliable clinical laboratory.

HOW TO CARE FOR RHEUMATIC FEVER CHILD AT HOME

"MOST PARENTS COULD use some ideas on how to cope with a sick child," states a new booklet published today by the American Heart Association and its affiliates.

Entitled "Home Care of the Child with Rheumatic Fever," the 24-page illustrated booklet was prepared especially for parents of youngsters for whom hospital treatment is either not advised or not available. Copies are available from local Heart Associations.

Issued as a companion piece to "Have Fun . . . Get Well," the popular Heart Association publication on recreational activities for the sick-abled, the new booklet contains basic information and hints useful in the care of sick children in general. It offers practical pointers on home nursing techniques and also includes suggestions for dealing with the psychological and emotional problems that are likely to arise when a youngster is confined to bed for more than a week or two.

"Every mother," states the booklet, "has noticed that a sick child tends to act a little babyish, a little younger, than when he is well. Even adults tend to be difficult and to act somewhat less mature when they are sick. It is important to understand this and not to expect too much of your sick boy or girl.

"In spite of his temporary illness, your youngster can learn to give and take, to serve others as well as

to be served, to recognize that other members of the family need attention too."

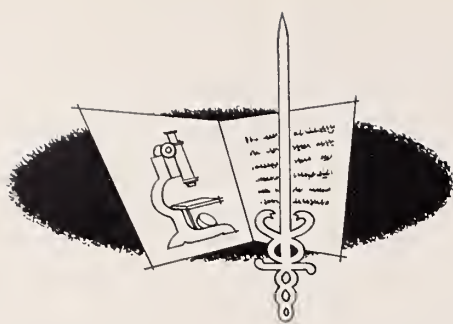
In discussing rheumatic fever, the booklet emphasizes that the illness and the convalescence may be of long duration. Bed rest is essential to recovery "as long as the disease is active."

"Rest is important," the booklet states, "because rheumatic fever may attack the heart. When the patient rests, his heart gets more rest too, and so, if the heart has been affected, it has time to heal."

Prevention of Repeat Attacks

Another important thing parents should remember in caring for a child with rheumatic fever is to protect him against the streptococcal infections that may bring on a recurrence, the booklet emphasizes, noting that "each new attack increases the danger of heart damage." Penicillin and other drugs may be prescribed by the physician to ward off new strep infections and thereby block rheumatic fever recurrences.

The booklet points out that it is necessary to explain to the sick child the importance of following the doctor's orders. The child should also be helped to accept some responsibility for planning and carrying out the limited activity routine while he remains in bed.



cancer page

THE PAPANICOLAOU METHOD FOR CANCER DETECTION

JACK C. NORRIS, M.D., *Atlanta*

AT CHICAGO in 1949, I had the happy privilege of hearing Doctor Pap make one of his first reports. I was deeply impressed; in fact, astonished at his good results. The method is perfect, that is, it is so in his hands. He has envisioned all of the hidden unique architectural features of the malignant cell perhaps as no other living man has ever been able to do; yet his procedure is not entirely new. For years histologists have been seeing individual cancer cells in secretions, but they dared not report them. They were reluctant to do that. Papanicolaou's contribution is an outstanding one because he dared to look, and look hard again, and had the conviction to positively say "positive." He stuck out his neck. He knew what he saw; he believed; and said so.

Ten years have passed since Chicago, and the revised method is used throughout the world. My experience has admittedly been limited, but I am certain that the Pap smears are excellent for use either in the small laboratory or large clinic, and the more one uses them, the more they become proficient; in fact, some apparently are becoming very clever with it.

With humility and apology, I admit that I have modified the staining technique to fit my competency; but I would insist that the younger cytologist stick closely to Pap directions, and not try to experiment on his suggestions. I have been able to find malignant cells in cervical smears, in material from

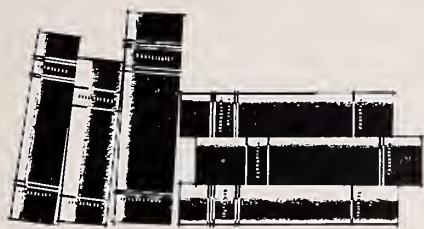
the lung, breast, peritoneal cavity, and colon. I have not been very successful in secretions from the stomach, urinary, and prostatic areas. I am frightened to try to find cancer in pleural exudates.

In several patients I have reported cervical cancer cells where we were unable to confirm as cancer by the tissue biopsy. That was embarrassing. Two patients later developed cervical cancers and were subjected to surgery. Most physicians, even in the face of positive Pap smears, hesitate to do anything to a normal looking cervix. That is a good and correct attitude, but it may be necessary to change these views in the future.

To make the smears properly is important, but placing them in a fixative other than ether-alcohol seems unnecessary. Simple dried slides often stain very readably.

A general summary, in which many join me, is this: the Pap method is simple, reliable, and very useful in detecting exfoliated malignant cells. Its use can help us find malignancies long before the gross picture shows up. However, it is our opinion that the *per primum* point in cancer diagnosis securely rests in the use of tissue biopsies from suspected regions where cancer is prone to occur, and examined histologically by experienced pathologists. Nothing I know of today has altered those principles.

Approved by Professional Education Committee, Georgia Division, ACS.



physician's bookshelf

BOOKS RECEIVED

Keynes, G. L., M.D., F.R.C.S. and Osler, Sir William, *A WAY OF LIFE AND SELECTED WRITINGS OF SIR WILLIAM OSLER*, Dover Publications, Inc., New York, N. Y., 1951, 278 pp., \$1.50.

Croxtan, Frederick E., Ph.D., *ELEMENTARY STATISTICS*, Dover Publications, Inc., New York, N. Y., 1953, 376 pp., \$1.95.

Steer, Charles M., M.D., Med.Sc.D., F.A.C.S., F.A.C.O.G., *MOLOY'S EVALUATION OF THE PELVIS IN OBSTETRICS*, W. B. Saunders Co., Philadelphia, Pa., 1959, 131 pp.

PROGRESS AND PROBLEMS OF COMMUNITY MENTAL HEALTH SERVICES, papers presented at the 1958 annual conference of the Milbank Memorial Fund, Milbank Memorial Fund, New York, N. Y., 1959, 228 pp., \$2.00.

DuVries, Henri L., M.D., *SURGERY OF THE FOOT*, The C. V. Mosby Co., St. Louis, Mo., 1959, 494 pp., \$12.50.

Wolstenholme, G. E. W., O.B.E., M.A., M.B., B.Ch. and O'Connor, Maeve, B. A., *CIBA FOUNDATION SYMPOSIUM—CARCINOGENESIS MECHANISMS OF ACTION*, Little, Brown and Co., Boston, Mass., 1959, 336 pp., \$9.50.

Wolstenholme, G. E. W., O.B.E., M.A., M.B., B.Ch. and O'Connor, Cecilia M., B.Sc., *CIBA FOUNDATION SYMPOSIUM—REGULATION OF CELL METBOLISM*, Little, Brown & Co., Boston, Mass., 1959, 387 pp., \$9.50.

Ross, Stuart T., M.D., F.A.C.S., F.I.C.S., *SYNOPSIS OF TREATMENT OF ANORECTAL DISEASES*, The C. V. Mosby Co., St. Louis, Mo., 1959, 240 pp., \$6.50.

REVIEWS

Lamm, Stanley S., M.D., *PEDIATRIC NEUROLOGY*, Landsberger Medical Books, Inc., New York, N. Y., 1959, 495 pp., \$12.90.

THE AUTHOR PRESENTS a timely book for the physician in any field of medicine today.

Outstanding is the order of organization of material with a refreshing newer approach to discussion of the various clinical entities which enhances the comprehension of the material. Of considerable interest is the discussion of specific therapy with daily care management and answers to questions encountered almost invariably in such problems. Dr. Lamm proceeds to dis-

cuss the contemporary research in the various fields related to neurological disorders with specific evaluation of procedures used in confirmation or differential diagnosis of related conditions. This book has 21 chapter titles which includes a number of the newly described diseases.

The book *Pediatric Neurology* will be a definite asset to the physician dealing with any neurological disorder in the child.

Preston D. Ellington, M.D.

Canfield, Norton, *HEARING, A HANDBOOK FOR LAYMEN*, Doubleday and Company, Inc., Garden City, New York, 1959, 214 pp., about \$3.50.

THIS BOOK CONSISTS OF 16 chapters. The first eight are devoted to a study of normal and subnormal hearing, and the causes and treatment of deafness with historical background. It is set up like a quick course for medical students, but is understandable to laymen. There are some questionable statements; for example, "further loss (hearing acuity) can often be prevented by using a hearing aid," and "The reasons for not smoking are infinitely more potent for people with hearing loss." Informative headings are not always followed by information; for example, beneath the caption regarding the function of ear wax, there does not seem to be a stated function for the ear wax.

Doctor Canfield hits his stride in chapters nine, ten, and 11 where he discusses hearing aids. Those in need will find help.

In chapter 12, he discusses noise in industry, which, though important, is of limited, specific interest, and chapters 13 through 16 provide consolation for the deaf via philosophy and rehabilitation.

To me, the greatest fault of the book is its prolixity. Rather than 214 pages, it might be more effective in 100 pages, maximum.

Lester A. Brown, M.D.

Boies, Lawrence R., M.D., *FUNDAMENTALS OF OTOLARYNGOLOGY*, W. B. Saunders Co., Philadelphia, Pa., 1959, 510 pp.

BECAUSE THIS BOOK takes up a good many of the modern concepts of disease and treatment it will be valuable not only to the otolaryngologist and resident in this field but probably equally so to the general practitioner

PHYSICIAN'S BOOKSHELF / Continued

and physicians in allied fields. Of particular interest to the otolaryngologist will be the discussions of hearing loss, both as concerns the medical treatment and prosthetic treatment as well as the surgical treatment of this condition. Also of value to the otolaryngologist is the discussion of facial injuries and maxillofacial repair and reconstruction. Of considerable help to the internist will be the chapters on tinnitus and vertigo which are such common complaints that an understanding of these conditions is very helpful in general medicine. Also of value to the internist and even the surgeon is the differential diagnosis of headache as concerns mechanism and etiology. All in all this book should be a valuable addition to the library of most physicians and one of the best written for the resident in otolaryngology to date.

A. P. Keller, Jr., M.D.

Moss, William T., M.D., THERAPEUTIC RADIOLOGY, The C. V. Mosby Company, St. Louis, Mo., 1959, 403 pp.

THE RATIONALE, TECHNIQUE, and results of conventional and supervoltage radiation therapy are discussed in a compact and uncommonly practical manner. With a readable style, the author presents a program of care for the cancer patient that is clinically oriented. His approach, obviously based on a personal background in clinical medicine, is refreshing.

The discussion is arranged according to the organs and tissues affected. Particularly superior are the chapters on the oral cavity and oropharynx, the breast and the hemopoietic tissues.

The author does not evade controversial points, and he candidly compares the competitive value of irradiation and surgery. There is no neglect of limitations, contraindications, and complications of radiation therapy.

The 146 figures include many dramatic "before and after" representations.

Unique and the outstanding feature of this book is a detailed discussion of the effects of irradiation on normal tissue, presented preliminary to each chapter concerned with specific lesions of a single organ or tissue.

J. Frank Walker, M.D.

Williams, Ralph C., M.D.; Armstrong, Margaret Bull, R.N.; Gunter, J. Fred, B.B.A.; McCulloch, Edith, R.N.; and Stiller, Jack, NURSING HOME MANAGEMENT, The F. W. Dodge Corporation, New York, N. Y., 1959, 230 pp., \$8.50.

THIS IS THE FIRST BOOK that has appeared dealing exclusively with the establishment, organization, and management of nursing homes and homes for the aged. This book endeavors to present information gathered from many sources that will serve as a guide for assisting those concerned with the operation of institutions providing care for the disabled and aged. Some of the persons now operating nursing homes or homes for the aged are registered nurses or licensed practical nurses. However, by far the majority of those engaged in this field have had no particular training for this type of work. For that reason some elementary material has been included in this book. It is intended to serve

as a reference source for persons of varying backgrounds who seek information in this general field.

Special topics in this book include useful information relating to: structural arrangement; maintenance of physical plant; business and personnel management; care of patients, food service for the aged; safety programs; fire protection; community and public relations. Many other important phases of operating nursing homes and homes for the aged are discussed in simple, understandable terms.

Riese, Walther, M.D., A HISTORY OF NEUROLOGY, MD Publications, Inc., New York, N. Y., 1959, 223 pp., \$4.00.

THIS BOOK IS A philosophical presentation of the historical development of knowledge in regard to the activity of the nervous system. There are nine chapters dealing with the following subjects: historical development of basic concepts of functions of the nervous system, history of knowledge of the nervous impulse, of reflex action, of the doctrine of cerebral localization, of the re-discovery of the whole, of pain, diagnosis, prognosis, and therapy of nervous diseases.

It portrays the history of neurology "as a gigantic conflict between dogma and tradition and experimental observation." The thesis is made that "all qualities of the brain are spatial, and only spatial phenomena occur within it, motion and sensations being the link between the brain and soul." For one with philosophical interest, the book is an enlightening historical resume.

W. A. Smith, M.D.

Roques, F. W., M.D., C.B.E., M.Chir., F.R.C.S., F.R.C.O.G., DISEASES OF WOMEN, The Williams & Winkins Co., Baltimore, Md., 1959, 556 pp., \$8.00.

THIS IS THE TENTH EDITION of an English textbook, the first edition having been printed in 1919. It is a good standard gynecology text and is primarily for the use of medical students. There are 63 chapters, and the contents are well illustrated, and in keeping with modern concepts of gynecology.

Carl J. Brunoehler, M.D.

**FOR COMPLETE
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SEE PAGE 435**

current clinical concepts

Fungus Infections of the Skin

A NEW ANTIBIOTIC called griseofulvin will soon be on the market, advertised as a treatment for "ring-worm." This new drug will be marketed as Fulvicin® by the Schering Corporation, and Grifulvin® by the McNeil Laboratories.

To date, this new antifungal, oral antibiotic has been shown to be quite effective for most of the fungus infections of the skin, but particularly for those caused by the *Trichophyton rubrum*. Most of the reports of therapeutic trials in man are few, and the series relatively small, but it appears to be a real "break through" in the treatment of the superficial fungus infections. It has a great advantage in that no severe toxic reactions have as yet been reported in its use, even in such large doses as two grams given daily. For most patients a half to one gram daily is sufficient to give symptomatic relief. On this dosage, within ten days, the cultures are negative, although the fungus can still be seen in the scrapings. However, it is not known at the present how long this drug may be taken to effect a cure. It seems highly probable that this antibiotic when taken by mouth is fungicidal, as well as fungistatic. It does not appear to be of any value for the deeper fungus infections.

Personal communication: Herbert S. Alden, M.D.

Paradox of the Paradoxical Pulse

IT WAS THE celebrated Kussmaul, who, in 1873, first suggested that the phenomenon be termed paradoxical, "partly because of the striking disproportion between the action of the heart and the arterial pulse, and partly because the pulse, although apparently irregular, shows in reality a regular waxing and waning." He said nothing about a reversal of the normal response of the pulse to the phases of respiration.

Editorial—New England Journal of Medicine, 1950, 242, 990.

Postwar Developments

MOST SIGNIFICANT among other developments of the postwar years have been the expiration and subsequent abandonment of vagotomy as a primary treatment; the

further abandonment of vagotomy combined with posterior gastroenteroscopy as a primary procedure; general disappointment with clinical results are very radical gastrotomy; the initial expiration of many new technical combinations, none of which have been used long enough to permit definitive evaluation; the description of the Ellison-Zollinger syndrome and other endocrine abnormalities as specific ulcer variance; the realization that patients with chronic broncho pulmonary disease are prone to ulcers; and that the decreasing incidence of duodenal-stump leakage and the emergence of necrotizing pancreatitis as the most dangerous lethal complication of gastric surgery.

J. R. Brooks and F. D. Mocre—N. E. J. Med. 1959, 260, 1124.

Myxedematous Neuropathy

PERIPHERAL NEUROPATHY MANIFESTED by severe lancinating extremity pain and/or paresthesias occurred in 47 per cent of 65 patients with spontaneous myxedema. It was the presenting and dominant complaint in three patients. The neuropathy may be the initial manifestation preceding the more overt symptoms of myxedema. Because of anemia, pallor, and neuropathy, myxedema is frequently confused with pernicious anemia. The motor and sensory symptoms are out of proportion to neurologic findings, and may be confused with the primary degenerative disease of the central nervous system, nerve root compression or hysteria. The neuropathy is completely reversible by adequate thyroid replacement alone.

L. E. Crevasse and R. B. Logue—Annals of Internal Medicine 1959, 50, 1433.

Serotonin Neuropathy

A PATIENT WITH an unusual neurologic disease characterized by ataxia, vasomotor instability, and dysautonomic seizures is described. Associated biochemical findings included hyperserotoninemia without corresponding 5-hydroxyindoluria. Evidence is presented that the patient metabolized endogenous serotonin via a different and as yet unknown alternate pathway.

A. L. Southern—N. E. J. Med. 1959, 260, 1265.

Severe Pyelonephritis of Pregnancy

WHAT MAY APPEAR to be toxemia of pregnancy could be pyelonephritis. A typical clinical manifestation may lead to diagnostic failure, and therefore pyelonephritis must be considered in cases of unexplained complications of pregnancy.

Getzoff, Paul L. and Fowler, Roger, Southern Medical Journal, Vol. 52, No. 6, pp 638: June, 1959.

Eighth Nerve Deafness After Administration of Kanamycin

NERVE DEAFNESS MAY be permanent and all but complete following the administration of kanamycin. (Abstractor's note: A similar case of nerve deafness following kanamycin administration).

Lustberg, Alfred and Hamburger, Morton, J.A.M.A., Vol. 170: pp 806, June 13, 1959.

CLINICAL CONCEPTS / Continued

Albamylin "Jaundice"

ALBAMYCIN IN RELATIVELY small amounts may produce a picture which is clinically indistinguishable from jaundice. Since the abnormal pigment in the blood stream is not bilirubin, blood bilirubin will be normal. This is not a rare occurrence.

Personal communication: Arthur J. Merrill, M.D.

An Evaluation of Internal Mammary Artery Ligation

FROM THE RESULTS in this rather small (seventeen) group of patients, bilateral skin incisions in the second intercostal space seem to be at least as effective as internal mammary artery ligation in the therapy of angina pectoris.

An Evaluation of Internal Mammary Artery Ligation by a Double-Blind Technic—N. E. J. Med. May 28, 1959, vol. 206, No. 22.

Common Sense in the Diagnostic Use of X-ray

THE CURRENT ALARM about radiation dangers must not prevent the intelligent use of X-rays in medical diagnosis. A respect for and not a fear of radiation is more desirable.

Miller, J. E. and Swindell, G. E., J.A.M.A., Vol. 170, No. 7: pp 761, June 13, 1959.

Epidemiology of Toxoplasmosis

THE WAY, OR more probably ways, in which toxoplasmosis is spread have yet to be found. A lead worth following was given by Cathie when he found toxoplasma in the saliva of a child. There are few fomites so widely spread, and in the search for an animal source it should not be forgotten that the animal with which man is most in contact is man.

An editorial — Epidemiology of Toxoplasmosis — Lancet 1959, 2, 869.

Alkaline Phosphatase of Mature Neutrophils In Various "Polycythemias"

THE ESTIMATION OF the enzyme (alkaline phosphatase) in mature neutrophilic granulocytes may constitute a reliable test of differentiation of polycythemia vera and other "polycythemias," provided that other causes of an increase in the alkaline phosphatase of the mature granulocytes (such as severe infection) are ruled out.

Alkaline Phosphatase of Mature Neutrophils in Various "Polycythemias"—N. E. J. Med. May 28, 1959, vol. 260, No. 22, p. 1131.

Bismuth Injections in Young Infants

BISMUTH INJECTIONS in infants or young children are not an uncommon cause of kidney shut-down in this age group. Bismuth should be given with great caution if at all to such patients. The mortality rate is high, but

with proper fluid restriction and use of the artificial kidney when needed, the process is reversible. Dialysis should be performed if the kidneys are not well opened up by the eighth day. Fluids should be restricted to 200 to 400 cc. plus output in 24 hours depending upon the weight of the infant. Only 20 per cent glucose or ginger ale should be given. No salt or sodium lactate. BAL is of no value if given after renal shut down has already occurred.

Personal communication: Arthur J. Merrill, M.D.

Hula Hoop's in Gynecology

THE DANGERS OF HULA-HOOPING in respect to the orthopedic relations of the intervertebral disks as well as to atheromatous arterial systems have been widely discussed. A new side effect on this form of undulant fever is reported by a correspondent to the *British Medical Journal* of March 21, 1959, in the case of a young woman who had managed, by dint of excessive hula-hooping writhing, to achieve partial torsion of an adherent tubo-ovarian cyst, with symptoms severe enough to justify surgical exploration.

N. E. J. Med. 260:1043, 1959.

Shotgun Therapy

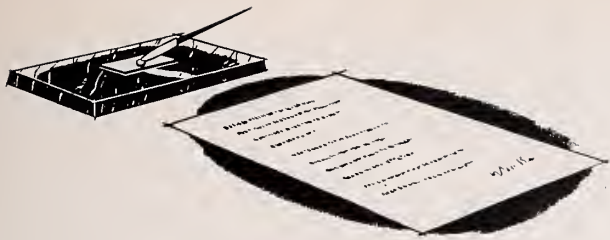
PREPARATIONS CONTAINING MORE than three ingredients may usually be regarded as therapeutically unsound. Those that may be acceptable are certain analgesic compounds such as acetylsalicylic acid and acetophenetidin, as well as preparations containing the essential vitamins in their recommended dosage. Preparations containing more than vitamins A, D and C, thiamine, riboflavin, niacinamide, and perhaps pyridoxine should, however, be looked upon with suspicion, since they are, for the most part, of unproved value and expensive. Those with two dozen or more ingredients border on the ridiculous. It is time to discontinue such top-heavy polypharmacy."

Friend, Dale G.: Polypharmacy—Multiple—Ingredient and Shotgun Prescriptions. N. E. J. Med. 260:1015, 1959.

Chlorpromazine Toxicity

MANY TOXIC EFFECTS have followed the use of chlorpromazine. Sudden hypotension, with weakness, fainting and collapse, frequently occurs when large doses are given parenterally, especially if the patient is ambulatory too soon. Usually, this effect passes if the patient remains recumbent for 60 minutes after receiving the drug. On rare occasions profound shock followed by death from the hypotensive effect has occurred . . . Jaundice resulting from biliary stasis is seen in approximately two per cent of patients receiving the drug. . . Agranulocytosis occurs about once in 50,000 patients on the drug. . . Dermatitis frequently develops on the hands of persons handling the drug. . . In patients given large doses of chlorpromazine the typical tremor, rigidity, and behavior of the patient with Parkinson's disease frequently develop. . . Sedation and drowsiness may be pronounced in some patients and require small doses or even discontinuance of the drug. Tachycardia, chilliness, dryness of the mouth, nausea, indigestion, vomiting, and constipation have all been observed. In rare cases lactation develops in females, and gynecomastia in males.

Current Concepts of Therapy. N. E. J. 260:1028, 1959.



abstracts by georgia authors

Quattlebaum, Julian K., Sr., and Quattlebaum, Julian K., Jr., 24 West Gaston Street, Savannah, Georgia, "Technique of Hepatic Lobectomy" Ann.Surg.149:648-651 (May) 59.

Excisional therapy for a number of hepatic lesions is now an accepted procedure. Accumulated experience indicates the operation can be done with reasonable safety, and with expectation of cure when performed for benign lesions and occasionally affords worthwhile palliation in malignancy. Major difficulties in resection of the liver are technical and the most important is the control of hemorrhage.

Important Steps in Massive Liver Resection

1. Adequate exposure through a large thoraco-abdominal incision.
2. Complete mobilization of the liver by dividing all its peritoneal attachments.
3. Dissection of the porta hepatis with individual ligation and division of the structures entering the involved lobe.
4. Division of the liver substance with a blunt instrument, rather than by sharp incision.
5. Ligation of smaller vessels with fine silk or cotton; control of oozing from the liver surface by Gelfoam packs and omentum; avoiding heavy mattress sutures through masses of liver substance.

The operability of hepatic lesions can be determined only by exploration. Any of the conventional laparotomy incisions can be converted into a thoraco-abdominal one, and the adequate exposure thus obtained is absolutely essential for major resection of the liver.

After the peritoneal attachments of the right lobe have been divided, the liver can be readily elevated, and the points of entry of the hepatic veins into the vena cava isolated and exposed. This is a dangerous step in the operation, as the veins are easily avulsed and the cava itself may be easily torn. The dissection of the porta hepatis is begun by opening the common duct and locating the hepatic ducts with a probe. This instrument should remain throughout the operation, so as to avoid injury to the hepatic duct being preserved. After the cystic duct is ligated and divided, the cystic artery is followed to the hepatic artery, the right branch of which is isolated, ligated, and divided. After dividing the right hepatic duct

further dissection readily exposes the portal vein and its right and left branches. After dividing the branch to the involved lobe, the stump is oversewn with a suture of arterial silk rather trusting to simple ligature.

Division of the liver with a sharp instrument results in profuse hemorrhage which is difficult to control because the vessels retract within the liver substance. If the section is made close to the falciform ligament with a blunt instrument, such as the handle of a knife, a closed scissors, or a small clamp, the liver substance is easily torn through, and the larger ducts and vessels are exposed without cutting them. They may be divided between clamps, as encountered and ligated individually with a minimum loss of blood. It is important to place a drain between the omentum and the raw liver surface to prevent the accumulation of bile and secretions which may otherwise lead to a subphrenic infection.

The postoperative course is usually tranquil, but the complications associated with any major thoraco-abdominal surgical procedure must be anticipated and dealt with promptly.

Expert anesthesia and adequate blood replacement facilities are essential to successful outcome.

Galambos, John T. and Peacock, Lamar B., 69 Butler Street, N.E., Atlanta, Georgia, "The Use of Chelating Agents in the Treatment of Acute Porphyria" Ann. Int. Med. 50:1056-1061 (April) 59.

The therapeutic value of any agent in the management of patients acutely ill with porphyria is difficult to evaluate because of the character of the disease itself. Recently, disodium calcium ethyl-andiamine tetra-acetate (EDTA) and BAL®, both chelating agents, were advocated for the treatment of patients with porphyria. A case of acute intermittent porphyria (AIP) is described with post-mortem examination. He was treated with EDTA on three separate occasions. Following each, his clinical course became worse. Review of the literature revealed a case reported by Schroder of an acute porphyria definitely induced as a first attack by repeated injections of BAL® given experimentally to a patient with hypertension.

The therapeutic value of EDTA in patients with porphyria who have increased lead soft tissue content is confirmed by our experience. However, in

patients with acute and chronic porphyria toxic amounts of other heavy metal, like zinc or copper, has never been proven. It was shown that one of the enzymes, delta-aminolaevulinic acid dehydrase, which takes part in the synthesis of porphobilinogen, is inhibited by zinc; however, this enzyme is also inhibited by EDTA itself. Many of the patients who have porphyria have chronic liver disease or, indeed, cirrhosis. Increased urinary zinc excretion in cirrhotics was demonstrated by Vallee et al. These patients had low serum and tissue zinc levels, but excreted increased amounts of zinc in the urine. A number of important enzymes are dependent on zinc for their activity, one of which participates in the metabolism of alcohol. Body store depletion of zinc in these patients theoretically could be harmful. Administration of EDTA in large doses by Berry and Schroder produced lesion simulating vitamin deficiency. In these experiments they were not able to demonstrate increased copper excretion while the patients lost large amounts of zinc, iron, and manganese.

Chronic cutaneous porphyria is characterized by the fecal excretion of large amounts of porphyrin. Schwartz and Zagaria found that neither lead, nor any of the other metals which they studied, produced a significant change in fecal porphyrin excretion. This observation suggests that these metals, which can interfere with normal porphyrin metabolism, did not produce the type of abnormality of porphyrin metabolism which is characteristic of porphyria cutanea tarda.

It is concluded that the use of chelating agents in porphyria may well prove useful, but today the therapy is experimental and the theoretical background on which this therapy rests is yet to be proven by experimental evidence. These therapeutic agents, as our case shows, could produce untoward effects in a patient with acute intermittent porphyria, and, as was shown by Schroder, it can precipitate acute porphyria *de novo*.

Murdock, James W. and Lawrence, John C., V.A. Hospital, Dublin, Georgia, "Resection of Left Lobe of the Liver for Hepatoma" Am. Pract. 10:657-659 (April) 59.

This case report concerns a 63 year old white male who was referred to the Veterans Administration Hospital, Dub-

ABSTRACTS / Continued

lin, Georgia because of a liver mass which had been biopsied by the referring physician and reported as metastatic carcinoma. The primary tumor was considered to be a polyp in the descending colon. A review of the slides at this hospital showed the tumor to be primarily liver. Therefore, the patient was explored and the left lobe of the liver resected. His tumor was confined to this area. Five months later, the abdomen was re-explored to repair a hernia and no evidence of tumor was found. The patient was re-examined in April of this year, four years after the initial surgery, and no evidence of residual disease was found. The case report also includes a review of some of the pertinent literature.

Floyd, Waldo; Lovell, Wood; and King, Richard E., 300 Boulevard, N.E., Atlanta 12, Georgia, "The Neuropathic Joint" South. M. J. 52:563-569 (May) 59.

The authors have reviewed approximately 30 cases of Charcot's joint. This condition most commonly occurs in central nervous system syphilis associated with tabes dorsalis. It is less frequently seen in syringomyelia and diabetes mellitus. The frequency of a neuropathic joint has decreased in the past decade, particularly in the group accompanying tabes dorsalis because of the rapidly dropping incidence of syphilis in all stages. Because of this, the physician must be on guard and think of this lesion in the person with osteoarthritis who presents evidence of neurological disease. The pathological manifestations of this disease were reviewed with particular emphasis on the destructive changes at the involved joint. The usual signs and symptoms which will aid in a clinical diagnosis were also innumerable. The pupils and reflexes

always deserve consideration. The early and late radiographic findings were emphasized. The treatment of a Charcot's joint may be either conservative or surgical. Amputation of a portion of the lower extremity is a frequent surgical procedure because of the marked joint instability and deformity. Arthrodesis of the various joints has been attempted but it has proved more successful in the knee than any other joint.

Lindberg, Evan F., Medical College of Georgia, Augusta, Georgia, "The Relationship between Perfusion Blood Temperature and Available Venous Return During Extracorporeal Circulation" J. Thoracic Surgery 37:663-672 (May) 59.

An investigation of some of the factors which control the rate of venous return to a mechanical heart-lung circulation was made. No significant changes in circulating blood volume, plasma specific gravity, and hematocrit values were found in dogs before and after the institution of a DeWall pump-oxygenator. The formation of an intravascular pool of blood, in the presence of an increased total peripheral resistance, was proposed as a possible explanation for the decrease in venous return when the extracorporeal circulation was started. The effect of alterations in the perfusing blood temperature on venous return was studied. The rate of venous return was found to parallel the rise or fall in perfusing blood temperature. Expansion of the circulating blood volume of the recipient animal was found to be effective in increasing the venous return only if the perfusing blood temperature was high.

Engler, Harold S.; Christopher, Phillip E.; Williams, H. Grady; Spears, Robert S.; and Moretz, William H., Medical College of

Georgia, Augusta, Georgia, "Prevention of Thrombus Formation in Small-Artery Anastomoses" Arch. Surg. 78:766-773 (May) 59.

In small artery anastomoses there is a tendency toward occlusion of the anastomotic site by thrombosis more than in large arteries. Because of this tendency for small vessel anastomoses to occlude, the techniques which have been so successful in large vessels often fail in small arteries. The purpose in this study was to modify to some extent certain factors which probably contribute to the development of thrombosis at the site of anastomosis in an effort to decrease the incidence of thrombosis. An attempt was made to modify the current of injury, normally present at a site of trauma, by creating a highly negative electrostatic field. The factor of stasis was diminished by (1) performing the anastomosis in such a way that the usual constriction would be eliminated and (2) by creating an A-V fistula distal to the end-to-end anastomosis to increase the rate of blood flow. Extension and enlargement of the minute thrombi present in the suture line was combated by 10 fibrinolysin and two Heparin®.

The paper outlines in detail the technique used in five groups of dogs and the results obtained.

In summary the authors conclude that under the conditions of the experiments no benefit was demonstrated by any of the measures that they used except heparinization. While various factors such as the current of injury, the presence of constriction at the anastomoses, and the rate of blood flow through the anastomoses are undoubtedly of some importance in determining the ultimate presence and absence of thrombosis, it seems from these experiments that the most important single factor is the coagulability of the blood.

GIFTS IN MEMORY AID HEART FUND

MEMORIAL GIVING TO the Georgia Heart Association offers a deeply satisfying year-round program through which many are able to translate their grief into some positive action and to help the living in the name of the departed.

This continuing program has developed in recent years to answer a growing desire on the part of those who have lost a relative or a friend through heart disease to contribute to a program concerned with combating the disease which caused the loss.

Memorial giving has become a major factor in the

support of the program of the Georgia Heart Association in areas of research, education, and community services.

Gifts to the Heart Fund in memory of friends, relatives, or associates will be gratefully and promptly acknowledged.

For more information or "In Thoughtful Tribute" leaflets and memorial gift forms, write to the Georgia Heart Association, 1101 West Peachtree Street, N.E., Atlanta 9, Georgia.

THE MONTH IN WASHINGTON

PRESIDENT EISENHOWER'S POWER of veto has been a powerful weapon in his fight against big spending programs of the Democrats.

His outstanding use of the power so far in this session of Congress was the veto of the Democratic, catch-all \$1,375,000,000 housing bill. Mr. Eisenhower said the measure was extravagant and inflationary. He warned that the fight against inflation could not be won "if we add one spending program to another without thought of how they are going to be paid for and invite deficits in times of general prosperity."

The housing bill included three provisions of interest to the medical profession. One provision, endorsed by the American Medical Association, would have authorized Federal Housing Administration guarantees of loans for construction of proprietary nursing homes. The second provision would have authorized direct federal loans for housing for interns and nurses. The third would have authorized both such loans and guarantees for housing for elderly persons.

Mr. Eisenhower objected to direct loans for housing for the aged. But he directed his main attack against the legislation's public housing and urban renewal provisions.

The President also vetoed a wheat price support bill which, he charged, "would probably increase . . . the cost of the present excessively expensive wheat program."

The threat of a veto also caused the Democrats to retreat and cut back their airport construction legislation.

These actions improved prospects for a balanced, or near-balanced, budget in the current fiscal year. Another factor working for a balanced budget is the economic upsurge which means more federal revenue than originally estimated.

But Congress voted more for medical research than the President wanted. However, all of it may not be spent because the President has the authority to hold back part of it.

The Senate voted \$481 million and the House, \$344 million, for the National Institutes of Health—as against \$294 million requested by Mr. Eisenhower. It was mandatory that a House-Senate Conference Committee, in working out a compromise between the House and Senate figures, approve a larger amount than the President requested.

The House Ways and Means Committee held hearings on the controversial Forand bill which would finance medical and hospital care of the aged through the social security system. Witnesses for the medical profession vigorously opposed the legislation. Dr. Leonard Larson, Chairman of the AMA Board of Trustees, and Dr. Frederick C. Swartz, Chairman of the AMA Committee on Aging, presented the AMA's views.

Representatives of various state medical societies either testified or presented statements in opposition to the legislation which would be financed through higher

social security taxes and which would cost about \$2 billion a year.

On another legislative front, AMA witnesses—Dr. George M. Fister, a member of the AMA Board of Trustees and Chairman of the AMA Council on Legislative Activities, and Dr. Vincent W. Archer, a member of the AMA House of Delegates and the AMA Committee on Federal Medical Services—testified before the Senate Finance Committee in support of a House-approved bill (Keogh-Simpson) that would provide tax deferrals for self-employed persons who invest in qualified pension or retirement plans.

Dr. Fister testified that high taxes and inflated living costs make it "difficult for the self-employed person to set aside adequate funds for retirement without a tax deferment similar to that available for corporate employees."

Experts from 17 nations gave favorable reports on use of live polio virus vaccine at a week's conference sponsored by the World Health Organization and the Pan American Health Organization.

However, the 61 experts conceded in a statement summarizing the conference discussions that problems remain in use of the vaccine which is given orally. Their main concern was with "the very difficult problems in the development control and evaluation of the safety and effectiveness" of the live vaccine. They also recognized that "the use of a product that spreads beyond those originally vaccinated represents a radical departure from present practices in human preventive medicine."

An advisory committee of the U. S. Public Health Service recommended a fourth shot of Salk polio vaccine as routine for children and adults under 40 years of age. The report also said that Salk vaccine shots could be beneficial for persons over 40 but was "less urgent" because they had polio less frequently than younger people.

Surgeon General Leroy E. Burney of the Public Health Service also issued an urgent warning that tragic polio outbreaks might occur this year if communities didn't push polio vaccination campaigns.

The Medical Society of the District of Columbia adopted a relative value scale of fees expressed in units rather than dollars. The basic unit of 1.0 is a routine office visit. The other relative values for medical services are multiples of the basic unit. For example: an appendectomy, 30 units; allergy skin tests, 2.0 units per 10 tests with a maximum of 15 units for multiple tests; anesthesia, first half-hour or any fraction thereof, 4.0 units.

It is not mandatory that the district medical society members charge fees conforming to the relative value scale. It was designed to show the relative value of a physician's services, particularly for health insurance purposes.

The AMA House of Delegates unanimously approved last year the study of relative value scales by state medical societies.



the association

ANNOUNCEMENTS

A postgraduate course in trauma sponsored by the Joseph B. Whitehead Department of Surgery in Atlanta will be held October 26-29, 1959 at Grady Memorial Hospital and Emory University Hospital. All phases of trauma are to be covered. This includes general as well as the specialties. Emphasis is placed on the common problems related to fractures which are encountered in the practice of most physicians.

Further information and the complete program can be secured by writing to: Chairman of Postgraduate Training, Department of Surgery, Emory University School of Medicine, Atlanta 22, Georgia.

The sixth annual meeting of *The Academy of Psychosomatic Medicine* will be held October 15-17, 1959 at the Sheraton-Cleveland Hotel in Cleveland. The meeting will be oriented and directed to fit the needs of non-psychiatric physicians. Practical everyday office management of psychosomatic problems and emotional disturbances will be dealt with in formal papers, symposia, panel discussions, and small study groups.

The meeting will be open to all scientific disciplines, as well as psychologists, social workers, and nurses. Information may be obtained from Dr. Bertram B. Moss, Suite 1035, 55 East Washington Street, Chicago 2, Illinois.

The American Rhinologic Society will hold its fifth annual meeting in the Belmont Hotel, Chicago, October 10. This will be preceded by a surgical seminar in the Illinois Masonic Hospital, Chicago, October 7-9.

The Sister Elizabeth Kenny Foundation announces continuation of its program of post doctoral scholarships to promote work in the field of neuromuscular diseases. These scholarships are designed for scientists at or near the end of their fellowship training in either basic or clinical fields concerned with the broad problem of the neuromuscular diseases.

The Kenny Foundation Scholars will be appointed annually. Each grant will provide a stipend for a five-year period at the rate of \$5,000 to \$7,000 a year depending upon the scholar's qualifications. Candidates

from medical schools in the United States and Canada are eligible.

Inquiries regarding details of the program should be addressed to: Dr. E. J. Huenekens, Medical Director, Sister Elizabeth Kenny Foundation, Inc., 2400 Foshay Tower, Minneapolis 2, Minn.

DEATHS

THOMAS F. ABERCROMBIE, 80, director emeritus of the State Department of Public Health, died June 14 in a private hospital.

Dr. Abercrombie, who lived in the Candler Hotel, Decatur, was born in Douglasville and moved to Atlanta in 1917.

A graduate of the Atlanta College of Physicians and Surgeons, now Emory University, he became executive secretary of the State Board of Health and served in that capacity for 30 years. In 1924 he was appointed by the U. S. Surgeon General to study health conditions in Europe for the League of Nations.

Dr. Abercrombie was president of the State of Provincial Health Authority in 1935 and won the L. G. Hardman Cup presented by the Medical Association of Georgia for "distinguished service to public health."

He completed his 30 years in 1947 and retired. In 1952 his book, "History of Public Health in Georgia," was published.

Dr. Abercrombie was a member of the Decatur Presbyterian Church, the American Medical Association, Medical Association of Georgia, and the Fulton County Medical Society.

Survivors include his wife; a daughter, Mrs. Richard P. Calhoon, Chapel Hill, N. C.; and a sister, Mrs. J. S. Abercrombie, Atlanta.

FLOY STERLING ROGERS of Coleman died at the age of 83, June 17 after a brief illness.

Dr. Rogers graduated from the Atlanta Medical College in 1897, the youngest graduate of the college

at that time. He did postgraduate work at New York Polyclinic and began the practice of medicine with his father. He continued his practice for 62 years in Coleman.

Dr. Rogers served as a member of the Randolph County Board of Education for 20 years, was a member of the County Commissioners' Board, and was a member of the Welfare Board for a number of years. He was named to "Who's Who" in 1951.

A one time mayor of Coleman, he was a member of the Alee Temple of the Shrine, Savannah. He served as a deacon of the Coleman Baptist Church where he was a member for many years.

Dr. Rogers was a member of the American Medical Association, Medical Association of Georgia, and the Randolph-Terrell Medical Society.

Survivors include his wife; a daughter, Mrs. Carl Thompson, Columbia, S. C.; a son, Dr. Floy S. Rogers, Jr., Washington, D. C.; a grandchild, Carroll Rogers, Washington, D. C.; and a step daughter, Mrs. Nelson Rippey, Ormond Beach, Fla.

SOCIETIES

Dr. Wendell B. Thrower of Charleston, S. C. addressed the members of the GEORGIA MEDICAL SOCIETY recently on the subject of "Surgical Correction of Calcific Aortic Stenosis."

Two Moody Air Force Base officials, Col. Henry K. Speed, Jr. and Maj. A. Donnelly, were guest speakers at the WARE COUNTY MEDICAL SOCIETY'S meeting.

Dr. Bob Ellison, Augusta, who is on the staff of the Talmadge Memorial Hospital discussed his work in cardiovascular surgery at a recent meeting of the WARE COUNTY MEDICAL SOCIETY.

PERSONALS

First District

Recently C. E. POWELL of Swainsboro was presented a certificate "for 10 years of uncompensated service to the Selective Service System."

WALTER R. VOYLES, formerly of Augusta, has begun the practice of surgery in Waynesboro and is a member of the staff of the Burke County Hospital.

Second District

DAVID PEARCE BELCHER of Pelham was honored recently by the Pelham Journal for 50 years of medical service.

The Tifton Lions Club saw a demonstration on hypnotism recently given by TOM EDMONDSON of Tifton.

Third District

ROYCE HOBBY of Ashburn has moved to Memphis, Tenn. to study orthopedic surgery at the Campbell Clinic.

Fourth District

CHARLES T. COWART of LaGrange recently met

with representatives of the Junior Red Cross of LaGrange High School, Troup High School, and Hogansville High School to discuss the composition and functions of blood in the body in order to acquaint them with the importance of the blood donor program of the American Red Cross.

JOHN D. BLACKBURN of Thomaston was one of the ten members of the 1909 Gordon Military College class to receive a commission of Honorary Colonel in the Gordon Cadet Corps.

Formerly of Atlanta, W. W. ALLEN now has offices in Forest Park. His practice will be limited to obstetrics and diseases of women.

WILLIAM P. ELLIS of Pine Mountain was given a surprise party in Hamilton by his many friends to celebrate "Doctor Ellis Day."

Fifth District

ARTHUR R. EVANS, JR., formerly of Forest Park has opened his office for general practice in College Park.

ROBERT H. BROWN of Atlanta spent the month of July in Europe studying certain techniques of microsurgery of the ear.

DAN B. KAHLE, national chairman of the Jaycee Community Health Program, was one of five Jaycees to receive the Seldon Waldo Memorial Award in Buffalo, N. Y.

The Sylvester Kiwanis Club heard an address by GUY V. RICE of Alpharetta, director of health conservation services for the state public health program, on the services offered by the State Department of Public Health in connection with the operation of the State Hospital at Milledgeville.

Sixth District

No news submitted.

Seventh District

No news submitted.

Eighth District

H. D. HEATH of Waycross addressed a meeting of the Waycross Association of Life Underwriters. In his address he urged insurance agents to make sure that the individual understands the type and degree of his coverage, particularly in the hospital, medical, and surgical categories.

Ninth District

HENRY S. JENNINGS of Gainesville was guest speaker at the regular meeting of the Gainesville Medical Assistants.

A. A. BOGGUS, formerly of Dahlonga, recently moved his office for general practice to Bradenton, Fla.

Tenth District

MERCER B. SELL of Augusta has been awarded a fellowship from the National Institute of Health for a three year residency in psychiatry to begin September 1 at the Eugene Talmadge Memorial Hospital.

DANIEL B. SULLIVAN recently completed a surgical fellowship at Memorial Center for Cancer and Allied Diseases in New York City and has opened his offices in Augusta.

ZEB L. BURRELL, JR. of Milledgeville had a scientific exhibit, based on a paper published in the American Journal of Cardiology, regarding the use of

tranquilizers in correcting certain irregularities in heart beat, at the annual meeting of the American Medical Association in Atlantic City.

Some facts about the early American Indians were related at a recent meeting of the Kiwanis Club of Augusta by JOHN T. PERSALL, assistant clinical professor of obstetrics and gynecology at the Medical College of Georgia.

EXECUTIVE COMMITTEE OF COUNCIL MEETING MINUTES

THE EXECUTIVE COMMITTEE OF COUNCIL was called to order at 11:10 A.M., June 21, 1959 in the Pine Room, Dempsey Hotel, Macon, Georgia by Executive Committee of Council Chairman Luther Wolff.

Members of the Executive Committee of Council present included Luther Wolff, Columbus, President and Chairman; Milford B. Hatcher, Macon, President-Elect; Lee Howard, Sr., Savannah, Immediate Past President; Chris J. McLoughlin, Atlanta, Secretary; J. G. McDaniel, Atlanta, Chairman of Council; Virgil Williams, Griffin, Chairman of Finance Committee. Also present were Henry H. Tift, Macon, Chairman Annual Session Committee and AMA Delegate; Robert L. Bennett, Warm Springs, Chairman, MAG Committee on Rehabilitation and Messrs. Krueger, Kiser, and Arndt of the MAG Headquarters Office.

Mr. Krueger read the minutes of the meetings of the Executive Committee of Council on May 20 and 28 and these were approved as read. Mr. Krueger also reviewed the Council minutes of May 16 and May 20, 1959 for information.

FUTURE MEETINGS—On motion duly made and seconded, it was voted to table a decision on whether or not MAG should be represented at the 7th National Conference on Physicians and Schools, October 13-14, Highland Park, Illinois. It was also voted to send Mr. Milton D. Krueger, Executive Secretary or Mr. John Kiser, Associate Executive Secretary as MAG representative to the Conference of Executive Secretaries in Miami, Florida, July 8-12, with expenses not to exceed \$125.00.

COMMITTEE ON REHABILITATION—Dr. McLoughlin introduced the new Chairman of MAG's Special Committee on Rehabilitation, Robert L. Bennett, Warm Springs. Dr. Bennett outlined objectives of the new committee as follows:

1. To stimulate an interest among the members of MAG in rehabilitation.
2. To inform the members on legislation pertaining to rehabilitation.
3. To assist in liaison with appropriate governmental and other agencies working in the field of rehabilitation.
4. To provide liaison services with para-medical groups working in the field of rehabilitation.
5. To provide information to the members and the public relating to the need for rehabilitation centers.

The membership of the Committee was discussed and it was decided that Dr. Bennett would submit names to President Wolff for appointment to the Committee. Various specialties are to be represented and it was requested that Dr. Bennett submit two or more names in each specialty.

HEALTH CARE OF THE AGING—In the absence of the Chairman of this Committee, Dr. John S. Atwater of Atlanta, Mr. Krueger presented the Chairman's progress report including a brief resume of the activity of Chairman Atwater. Mr. Krueger stated that Dr. Atwater had attended the First National Conference of the Joint Council to Improve the Health Care of the Aging, June 12-13 in Washington, D. C., and had also addressed the Annual Convention of the Georgia Association of Nursing Homes. He stated that Dr. Atwater plans to meet with the members of his committee individually. Mr. Krueger

outlined plans for the formation of a Georgia Joint Council to Improve the Health Care of the Aging and plans for contacting Governor Vandiver to discuss formation of the Governor's Committee of Aging. (A copy of the Committee's full report is on file in the Headquarters Office).

In regard to the recommendations of the Chairman of the Health Care of the Aging Committee, the Executive Committee of Council's actions were as follows:

1. The Executive Committee of Council of the Medical Association of Georgia unanimously approves the recommendation that MAG participate in the "Georgia Joint Council to Improve the Health Care of the Aging."

2. The Executive Committee recommends that Council provide an additional \$500.00 to be appropriated for the MAG Committee on Health Care of the Aging; these funds to be appropriated from the contingent fund.

3. The Executive Committee recommends that Council, because of special problems and urgency in handling the activities of this important Committee, authorize the intra-state travel and telephone expenses of Chairman Atwater.

4. That Mr. Krueger be authorized to attend the Ann Arbor Conference on Aging, June 24-27 with Dr. Atwater.

5. That Robert L. Bennett, Warm Springs, Chairman, MAG Committee on Rehabilitation, be appointed to the MAG Committee on Health Care of the Aging.

6. That the Executive Committee endorses the proposed meeting with Governor Vandiver, details of this meeting to be worked out by Dr. Atwater in consultation with Dr. Wolff.

7. It was voted that Executive Committee authorize the Secretary to send a letter of appreciation to Dr. Atwater for his fine report and the excellent work he is doing in this important field.

COMMITTEE APPOINTMENTS

a. *Legislation*—John Venable, Superintendent of the Milledgeville State Hospital, was appointed to the MAG Committee on Legislation.

b. *Woman's Auxiliary Advisory Committee*—William R. Dancy, Savannah was appointed to this Committee.

c. *Council Committees*—Dr. McDaniel reported on his appointments of committees of Council as follows:

Finance

Virgil Williams, Griffin, *Chairman*
Charles R. Andrews, Canton
George Alexander, Forsyth

Committee Reorganization

W. G. Elliott, Cuthbert, *Chairman*
J. W. Chambers, LaGrange
Thomas W. Goodwin, Augusta

Cultist

F. G. Eldridge, Valdosta, *Chairman*
Robert L. Brown, Atlanta
Raymond F. Spanjer, Cedartown
Albert M. Deal, Statesboro

Standardization of Insurance Forms

Joseph B. Mercer, Brunswick, *Chairman*
W. Lynn Hicks, Macon
Charles Cowart, LaGrange

Headquarters Building

Chris J. McLoughlin, Atlanta, *Chairman*
Virgil Williams, Griffin
J. G. McDaniel, Atlanta
Luther H. Wolff, Columbus
Milford B. Hatcher, Macon
Lee Howard, Sr., Savannah

Medical School Course

Chris J. McLoughlin, Atlanta, *Chairman*
Rafe Banks, Gainesville
T. A. Sappington, Thomaston

Clarksville Lab School

Charles Andrews, Canton, *Chairman*
Hamil Murray, Gainesville
Lee Howard, Jr., Savannah
Paul T. Scoggins, Commerce
Sam Talmadge, Athens

Annual Session

Henry H. Tift, Macon, *Chairman*
George Alexander, Forsyth, *Co-Chairman*
Peter Hydrick, College Park (Commercial Exhibits)
Ted Leigh, Atlanta (Scientific Exhibits and Meeting Rooms)
Raymond Arp, Atlanta
Simone Brocato, Columbus

Ancillary Personnel

W. S. Dorough, Atlanta, *Chairman*
Ralph W. Fowler, Marietta
John T. Godwin, Atlanta

Distinguished Service Award

David Henry Poer, Atlanta, *Chairman*
C. J. McLoughlin, Atlanta
Virgil Williams, Griffin

Lecture

George Alexander, Forsyth, *Chairman*
Mark S. Dougherty, Jr., Atlanta
J. W. Chambers, LaGrange

Health Care of the Aging

John S. Atwater, Atlanta, *Chairman*
Harry Brill, Columbus (Geriatrics)
Milford B. Hatcher, Macon (Hospital Relations)
T. A. Peterson, Savannah (Industrial Health)
David R. Thomas, Augusta (Insurance and Economics)
J. Frank Walker, Atlanta (Legislation)
R. J. Van de Wetering, Atlanta (Mental Health)
H. J. Bickerstaff, Columbus (Public Health)
Albert L. Morris, Fairburn (Rural Health)
John P. Heard, Decatur (Public Service)
Robert L. Bennett, Warm Springs (Rehabilitation)

ANNUAL SESSION CHANGE RECOMMENDATIONS—After discussion, the following changes were recommended in the Annual Session programming:

(1) The First General Session of the Annual Session should commence at 2:00 P.M., Sunday afternoon and be devoted to the nominations of general officers and councilors. At this same time, in addition to the nominations of the general officers and councilors, nominations for the "GP of the Year Award" and the "Hardman Award" will be made at this first General Session.

(2) That a Second General Session will be held Monday at 11:30 A.M., with a "Welcome" by the Mayor and Invocation and an introduction of Distinguished Guests. Following this opening ceremony, the outgoing President will give his Report to the general membership and following this Report, the incoming President (President-Elect) will make his address.

(3) That the awarding of the golf prize awards will be deleted from the final General Session held Wednesday morning.

(4) That voting for the general officers and councilors will commence at 2:30 P.M., Sunday and close at 5:00 P.M., Tuesday afternoon. The "GP of the Year" award and the "Hardman Award" nominees will be voted on by the House of Delegates at the usual time.

(5) That the Scientific Sessions on Sunday will open at 2:30 P.M. immediately following the First General Session, rather than at 2:00 P.M. as in the past.

(6) That medical student participation in the Annual Session will be encouraged.

These changes were approved as recommended by the Executive Committee of Council to the Annual Session Program Chairman Henry Tift, Macon.

WORKMEN'S COMPENSATION FEE SCHEDULE REQUEST—Secretary McLoughlin read a communication of May 8 from the California Medical Association requesting the fee schedule approved by the State Association for the Workmen's Compensation Act in the State of Georgia. On motion duly made and seconded, it was moved to refer this query to the Industrial Health Committee for reply.

PARA-MEDICAL EDUCATION LETTER—Secretary McLoughlin read a communication of June 8, 1959 from Dr. R. C. Williams, Director of the Division of Hospital Services, State Department of Public Health. This letter requested cooperation of the Medical Association of Georgia in forming a Council on "Joint Para-Medical Education." Dr. Williams further requested that a MAG representative be designated to serve on this Council. On motion duly made and seconded, it was voted that W. S. Dorough be appointed the MAG representative to serve on this "Joint Para-Medical Education Council" and further that Dr.

Dorough serve as Chairman of the Council Committee on Ancillary Personnel with Ralph Fowler and John Godwin serving as members of this Committee.

AMA NEWS REQUEST FOR DATA—Secretary McLoughlin presented a request from the *AMA News* for data on the actual cost of service incurred by a top officer of a state medical society. The letter indicated the information requested was the per cent of usual income sacrificed during the term of office in performance of society duties. It was recommended that Secretary McLoughlin query the Association five past presidents to ascertain this approximate amount and so notify the *AMA News*.

HUGHES SPALDING PAVILLION PROBLEM—Immediate Past President Lee Howard, Sr. brought to the attention of the Executive Committee certain problems in the practice of Pathology at the Hughes Spalding Pavillion, Atlanta. After discussion, on motion duly made and seconded this matter was tabled with the recommendation that Chairman of Council J. G. McDaniel seek further information on the alleged practices and so report at the July Council meeting.

EMANUEL COUNTY CHIROPRACTIC PROBLEM—Immediate Past President Lee Howard, Sr., presented the problem of an Emanuel County chiropractic practice which was referred to the Council Cultist Committee.

FINANCE COMMITTEE MONTHLY REPORT—Finance Committee Chairman Virgil Williams presented a monthly report of the budget and expenditures of the Association which was accepted as presented. It was recommended that the matter of re-budgeting the attorney retainer fee be referred to the July meeting of the Council for action.

HEADQUARTERS OFFICE REPORT—Mr. Krueger discussed the activity and status of the Headquarters Office personnel; a Planning Committee for the occupancy of the new MAG Headquarters Office; and the recommendation of the purchase of a check writing machine. Executive Committee action on these matters were as follows: It was recommended that the present MAG Building Committee of Council act as the Planning Committee and hold a meeting at the time of the August Executive Committee meeting in Atlanta; and further that Executive Committee recommend to Council the purchase of a check writing machine.

MEDICARE REPORT—Mr. John D. Arndt, Medicare Administrator, presented a brief report on the activities of the office. He pointed out that volume of claims had declined to 30 to 35 per cent of the former volume. He stated that Review Board members throughout the state have served a year and he recommended that these Review Board members be re-appointed. On motion duly made and seconded, it was voted to inform the Review Board members that they were reappointed for another term of office on authority of the President and Executive Committee. Mr. Arndt reviewed the status of employees in the Medicare office and the general activities of the office and it was voted to approve his administrative procedures.

MAG ANNUAL SESSION ACTIONS—Mr. Krueger presented certain recommendations of the House of Delegates for the information of the Executive Committee and received advice on the administering of these House of Delegates recommendations.

UNFINISHED BUSINESS

Distinguished Service Award—Lee Howard, Sr. reported that the late Dr. Hal M. Davison had been voted recipient of the Distinguished Service Award for 1959 by a secret committee appointed by the President and it was decided to place this matter on the agenda for the next meeting of Council.

Talmadge Hospital Liaison Committee—Chairman McDaniel presented a letter from W. Bruce Schaefer, Toccoa, in which he submitted his resignation as chairman of this committee. On motion duly made and seconded it was voted to instruct Chairman McDaniel to write Dr. Schaefer and ask Dr. Schaefer to reconsider this resignation.

Dr. McLoughlin submitted a Grievance Committee problem that was referred to the Professional Conduct Committee.

It was decided that the Executive Committee would hold its next meeting at the time of the Council meeting, July 25, 26, 1959 in Dalton, Georgia.

The meeting was adjourned at 4:35 P.M.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Brown, John M.	35 Linden Ave., N.E. Atlanta	Active	Fulton
Brown, Nelson H.	Milledgeville State Hospital Milledgeville	Active	Baldwin
Burgess, George L., Sr.	118 N. Park Carrollton	Active	Carroll-Douglas- Haralson
Burns, Emil E.	80 Butler Street, S.E. Atlanta 3	DE 2	Fulton
Cornejo, Carmen R.	300 Boulevard, N.E. Atlanta 12	Active	Fulton
Dunbar, Wm. G.	101 Third Street, N.E. Atlanta	Active	Fulton
Gersing, Albert	Emory University Hospital Atlanta	DE 2	Fulton
Guillebeau, James G.	Medical College of Georgia Augusta	DE 2	Richmond
Herndon, Euclid G., Jr.	Emory University Clinic Atlanta	Active	Fulton
Hibbert, Wm. A., Jr.	Grady Memorial Hospital Atlanta	DE 2	Fulton
Jones, R. Lanier	80 Butler Street, S.E. Atlanta	DE 2	Fulton
Malone, Lillian	821 Maxwell House Augusta	Active	Richmond
Mathney, James T.	16 Hospital Circle Rome	Active	Floyd
Morgan, Mary E.	VA Hospital Augusta	Service	Richmond
Rheney, Theodore B.	West Church Street Swainsboro	Active	Emanuel
Smith, Samuel R.	Milledgeville State Hospital Milledgeville	Active	Baldwin
Varela, Fernando L.	272 Ivy Street, N.E. Atlanta	Active	Fulton
Wall, Wm. H.	Blakely	Active	S. West Georgia

AMA TESTIMONY ON FORAND BILL

Mr. Chairman and Members of the Committee:

I am Dr. Leonard Larson of Bismarck, North Dakota. I am appearing here today as the Chairman of the Board of Trustees of the American Medical Association.

Slightly more than one year ago, I appeared before this Committee and pledged the American Medical Association to a dedicated, continuing effort in the field of health care for the aged.

I am proud to be able to tell you that the American Medical Association is making good on that pledge.

I say this with humility, because the very real progress being made represents the cooperative effort of hundreds of thousands of our citizens—doctors, nurses, dentists, social workers, hospital staff members, insurance company personnel, community and religious leaders—all working voluntarily together to do the job.

It is also to the credit of these private citizens that they are proving their ability to do the job in their own communities—and to do it effectively and well. A few specifics from their record of accomplishment are appended to our testimony.

At this time it is enough to say that retirement villages, new nursing homes, chronic disease care centers, home care programs, recreational facilities, and research projects have been established and that many, many more are on the way.

The medical profession takes pride in the part it has played thus far, and accepts its continuing role of leadership and support in the years ahead with confidence. We believe that the ultimate solution to the problems that remain must be found in private and voluntary action at the community level, and in private health insurance.

Voluntary Health Protection Insurance

Let me say a few words on the subject of voluntary health protection insurance, which has made revolutionary progress since World War II. Yet as rapidly as it has expanded in that period it seems to be gaining momentum still.

At the end of 1945, only 32 million people were covered by voluntary health insurance. But by the end of 1958, the number had soared to 123 million.

Putting it another way, fewer than one American

out of three in 1945 had voluntary health insurance. Yet today, the figure is nearly three out of four.

This is important, because it indicates that prepayment plans and the health insurance industry, by providing more and expanded health coverage for all age groups, are anticipating and solving tomorrow's health care financing problem of the aged.

H.R. 4700 fails to take into account the ever-increasing number of persons who will be covered by private health policies when they reach age 65, and the increasing public awareness of the value of voluntary health insurance protection.

A.M.A.'s Proposal

Last December, the A.M.A. House of Delegates, aware of medicine's responsibility in this regard, adopted a proposal which applies specifically to those over 65 with modest resources or low family income. This proposal urged physicians to set their fees at a level which will encourage the continued development of insurance and prepayment plans at reduced premiums.

Our state and local medical associations have been moving promptly to make this policy effective.

I am happy to report that there are now 25 plans in 23 states offering Blue Shield programs for those over 65. Further, in 16 other states, our medical societies, in cooperation with the plans they sponsor, are working out plans of a similar nature.

Blue Cross-Blue Shield Is Only Part of Story

The progress of Blue Cross and Blue Shield is only part of the story. An ever-increasing number of private insurance companies are now making initial coverage available to those over 65 on an individual basis and, at the same time, improving the type of health insurance coverage provided.

According to the Health Insurance Association of America, 60 per cent of our senior citizens who need and want health insurance will have protection by the end of next year. Further, that percentage will increase until three-quarters will be covered in 1965, and 90 per cent in 1970.

Private insurance and prepayment plans are rapidly doing the job.

But their gains would be nullified by passage of H. R. 4700, which would undermine and gradually replace voluntary health insurance if it were allowed to become law. Few people would be willing or able to carry both government and private plans.

In addition to discussing the progress which has been

Statement of the American Medical Association regarding H.R. 4700, 86th Congress, to the Ways and Means Committee, U.S. House of Representatives, July 15, 1959, by Leonard Larson, M.D., Chairman of the Board of Trustees of AMA.

made in developing financing mechanisms, it should also be remembered that the medical profession has, for many years, intimately concerned itself with the health care of the aged. I believe that the record of medical accomplishment attests to the fact that we have translated this concern into positive action. It should be understood in this connection that medical progress is linked irrevocably with the opportunity of medical researchers and practitioners to work with complete freedom.

Medical Advances

Since the beginning of the Twentieth Century, medicine has made revolutionary advances that have lengthened life and opened entirely new approaches to

curing illnesses. Since 1900, better medical care has increased the life expectancy of the average American by 20.5 years.

This means that the medical profession itself has helped to swell the ranks of our aged population. We are proud of this, and are convinced that we can meet future challenges in the same way, with the same success, and with the same benefits to mankind.

We believe, therefore, that any proposal that would undermine or destroy the voluntary progress we are now making should be defeated. We believe a federal compulsory health care system can lead only to disillusionment and to inferior medical care for those millions of older citizens who deserve the opportunity of making their extra years rewarding.

BLUE SHIELD TESTIFIES AGAINST FORAND BILL

Blue Shield Plans do not favor enactment of legislation providing medical care coverage for persons eligible for Social Security benefits, Dr. Donald Stubbs, Chairman of the Board of Directors of the National Association of Blue Shield Plans, told a House Committee on July 17.

Dr. Stubbs testified on behalf of the nationwide Blue Shield Plans before the House Ways and Means Committee, which has conducted hearings on HR 4700, a bill which would add hospital and medical care benefits for elderly persons under the Social Security system.

Instead of legislation, Dr. Stubbs strongly urged the House Committee to "permit, and encourage, and push the expanding development of voluntary methods to improve health care for the aged, outside as well as inside the Social Security system."

Dr. Stubbs reminded the Committee that in a previous appearance one year ago he had reported that Blue Shield Plans had approximately 2½ million persons over age 65 enrolled at the end of 1957 and that this significant figure had been achieved without special programs for the aged but instead by including them as a part of the whole community.

In what he termed a progress report to the Committee, Dr. Stubbs stated that Blue Shield Plans "share with many others the satisfaction of having made great strides towards understanding and planning realistically to improve the health care of the aged. Doctors and nurses, hospitals and nursing homes and the great army of their helpers have joined with leaders in Government, in industry and in labor in facing up with brighter awareness to this great problem. Blue Shield, along with many others, acknowledges the existence of the problem and supports the objective of solving it. The differences that may exist among us are those arising from honest convictions as to the best way to support a worthy cause. It is always a proper part of our democratic process to debate questions of method."

Progress Made by Blue Shield

Dr. Stubbs then reported on the significant progress made by Blue Shield Plans since the passage in December, 1958 of the American Medical Association resolution, urging the development of programs to provide senior citizens with suitable health care coverage. He indicated that, at present, 24 of the 65 Blue Shield Plans located in the United States, with about one-third of the total Blue Shield membership, offer nongroup enrollment coverage to those over the age of 65. In comparison, a year ago, only four Plans offered such programs, although all Plans permitted continuation of coverage to any age if acquired before age 65. In addition, there are four more Plans, embracing 17 per cent of total Blue Shield membership, with programs already approved but not actually in effect at this date because of minor details to be ironed out. There are 25 Plans, with 41 per cent of total Blue Shield membership, that have programs in various stages of development and under consideration; only 12 Plans, covering eight per cent of total membership, do not have special programs that can be recorded at this time. "Thus," Dr. Stubbs revealed, "about 92 per cent of the total Blue Shield enrollment is in areas where special programs for the care of aged are already in being or are in stages of development at this moment."

In conclusion, Dr. Stubbs stated that "We believe that in the half year since the beginning of the concerted effort to add these programs to our regular ones, this is a remarkable showing of the vigor that can be associated with the voluntary effort. Beginning slowly in widely separated areas but coming to a crescendo of activity we have here a broad picture of the accelerating development which we believe will solve this problem in the best way that it is solvable if allowed and encouraged to continue along these lines. Furthermore, this development aids the field of voluntary health insurance generally; we firmly believe this to be in the national interest."

Constitution and Bylaws of the Medical Association of Georgia

As revised by the House of Delegates at the *105th Annual Session May 20, 1959
(Supersedes Any MAG Constitution and Bylaws Prior to May 20, 1959)

CONSTITUTION

ARTICLE I.

Name of the Association

The name of this organization is The Medical Association of Georgia. It is an Association of its component county medical societies.

ARTICLE II.

Purposes of the Association

The purposes of the Association are to promote the science and art of medicine and the betterment of public health.

ARTICLE III.

Component Societies

Component societies are those county medical societies which hold charters from this Association or which may hereafter be organized and chartered by the House of Delegates of this Association which will form the Medical Association of Georgia.

ARTICLE IV.

Membership

SECTION 1. MEMBERS. The members of the Association are the members of the component county medical societies. The Association is composed of Active, Service, Associate and Honorary members as provided for in the Bylaws. Other types of membership may be provided for in the Bylaws.

SECTION 2. TENURE OF MEMBERSHIP. A member shall retain his membership as long as he complies with the provisions of the Constitution and Bylaws of this Association and with the Principles of Medical Ethics of the American Medical Association.

ARTICLE V.

House of Delegates

SECTION 1. COMPOSITION. The House of Delegates is composed of delegates elected by the component county medical societies as provided in the Bylaws. The general officers, the Past Presidents of the Association, the Treasurer, Editor of the Journal, delegates to the AMA, the Executive Secretary and chairmen of standing committees shall be ex-officio members of the House of Delegates without the right to vote.

SECTION 2. DUTIES. The House of Delegates is the legislative body of the Association, and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and Bylaws.

ARTICLE VI.

Council

SECTION 1. COMPOSITION. The Council is composed of the President, the President-Elect, the Immediate Past President, two Vice-Presidents, the Secretary, the Speaker of the House of Delegates and ten Councilors as provided for in the Bylaws. The Treasurer, Editor of the Journal, Executive Secretary and delegates to the AMA shall be ex-officio members of Council without the right to vote. Vice-Councilors shall be ex-officio members except in the absence of their respective Councilors as provided for in the Bylaws. The Vice-Speaker shall be an ex-officio member except in the absence of the Speaker as provided in the Bylaws.

SECTION 2. DUTIES. The Council is the Board of Trustees and the Board of Censors of the Association. It carries out the mandates and policies as determined by the House of Delegates. The Council has full authority and power of the House of Delegates between sessions of that body. The Council has charge of all property and financial affairs of

the Association and performs such duties as are prescribed by law governing directors of corporations or as may be prescribed in the Bylaws.

ARTICLE VII.

Meetings

SECTION 1. ANNUAL SESSION. The Association shall hold an Annual Session at a time and place fixed by Council.

SECTION 2. HOUSE OF DELEGATES. The House of Delegates shall meet during the Annual Session and in interim sessions as may be determined by Council.

SECTION 3. SPECIAL MEETINGS. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of Council, twenty delegates or upon written petition of one-fourth of the members of the Association.

ARTICLE VIII.

District Societies

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into councilor districts and for the organization of all component county societies in the districts into councilor district medical societies.

ARTICLE IX.

Officers

SECTION 1. DESIGNATIONS. The officers of the Association shall be a President, President-Elect, two Vice-Presidents, the Immediate Past President, the Secretary, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, ten Councilors, and ten Vice-Councilors as provided for in the Bylaws.

SECTION 2. ELECTION AND ELIGIBILITY. The officers of the Association shall be elected during the Annual Session as provided for in the Bylaws. No member shall serve as an officer who has not been a member of the Association for the preceding three years.

SECTION 3. TERM OF OFFICE OF PRESIDENT-ELECT. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. If the President-Elect shall be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session.

SECTION 4. TERMS OF OTHER OFFICERS. Other officers shall be elected for terms of one year each except the Secretary, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, and the Councilors and Vice-Councilors, who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.

SECTION 5. SUCCESSOR TO THE PRESIDENT. If the President dies, resigns, or is removed from office, the First Vice-President shall immediately become President and shall serve for the remainder of the unexpired term. If the First Vice-President is unable to serve, then the Second Vice-President shall fill the office.

ARTICLE X.

Funds and Expenditures

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component society. The amount of the assessment shall be set by the House of Delegates upon recommendation of Council. Funds may also be raised by voluntary contribu-

tions, from the Association's publications, and in any other manner approved by Council. The Council shall submit an annual budget to the House of Delegates and shall manage the finances of the Association.

ARTICLE XI. Official Publication

The official publication of the Association shall be the *Journal of the Medical Association of Georgia*, in which shall be published all official Association notices, abstracts of transactions of the House of Delegates and general meetings of the Association, the annual budget, complete financial reports as directed by Council, and abstracts of meetings of Council.

ARTICLE XII. Seal

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII. Amendments

The House of Delegates may amend this Constitution at any session by a two-thirds vote of the delegates present, provided that the proposed amendment shall have been introduced at the preceding session and provided that the proposed amendment shall have been published during the year in the *Journal*.

BYLAWS

CHAPTER I. Membership

SECTION 1. A physician holding the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who is a citizen of the United States, and who has not been judged guilty of moral turpitude or other serious crime, may be eligible for membership after being certified by the Secretary of a component society as being a member in good standing of said component county society.

SECTION 2. The name of a physician recorded on the official roster of a component county society, who has paid the annual dues and assessments of the component county society and of the Association, shall be prima facie evidence of membership in the Association.

SECTION 3. Membership in the Association shall be classified as Active, Service, Associate, and Honorary. All eligible members should be encouraged to be active members.

SECTION 4. ACTIVE MEMBERS. Physicians who are members in a component county medical society and are eligible to vote and hold office in the society shall be Active Members, unless otherwise classified by action of the component county society. These members shall have full privileges of Association membership including the right to hold office and vote, the privilege of Medical Defense and receipt of the *Journal of the Medical Association of Georgia*, and these members shall pay full dues to the Association annually. New members entering practice after July 1st may pay one-half the annual dues.

Active members may be excused from the payment of Association dues for one of the following reasons: (1) financial hardship or illness, (2) postgraduate training, defined as that period during which a member participates in an organized training course within a hospital, (3) being retired from active practice, or (4) on temporary service, as full-time commissioned Medical Officers in the Reserve Armed Forces. A member excused from the payment of annual dues for service in the Armed Forces shall not be required to pay annual dues for the period beginning January 1 or July 1 following the date of the member's entrance into service. (5) A member in good standing who is over 70 years of age may also be excused from the payment of Association dues upon his application to the Association through his component county society; this exemption to begin the year following the member's 70th birthday. Active members excused from the payment of Association dues shall have the right to vote and hold office but shall not have the privilege of Medical Defense and shall not receive any publication of the Association except by personal subscription. Nothing in this section shall be construed to be retroactive to affect previously elected Life Members.

SECTION 5. SERVICE MEMBERS. Physicians eligible for Service

Membership are all full-time commissioned Medical Officers of the Government, in the U. S. Army, Navy, Air Force, United States Public Health Service, Veterans Administration, and Indian Service, and those physicians who have retired from the Services by federal law. Such members shall not be required to pay the annual dues and shall not be entitled to vote and hold office and shall not have the privilege of Medical Defense, nor shall they receive any publication of the Association except by personal subscription.

SECTION 6. ASSOCIATE MEMBERS. Associate membership may be granted to physicians who are engaged in state and county medical services and full-time salaried members of approved medical faculties provided similar action has been taken by the component county society. Associate membership, except as otherwise provided herein, also may be granted to any member of a component county medical society. Associate members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to the privilege of Medical Defense or to receive any publication of the Association except by personal subscription.

SECTION 7. HONORARY MEMBERS. Physicians and persons holding the degree of Doctor of Philosophy who have risen to prominence in their professions may be elected to Honorary Membership by the House of Delegates. Nominations for Honorary Membership may be submitted to the House of Delegates by component county societies or Council. These members shall enjoy all the privileges of the Association but shall not vote or hold office nor shall they receive the privilege of Medical Defense or any publication of the Association except by personal subscription.

SECTION 8. TENURE. When the Secretary is officially informed that a member is not in good standing in his component society, he shall remove the name of that member from the membership roll.

SECTION 9. TRANSFER. Should a member remove his practice to another jurisdiction he shall apply for a continuance of his membership through the component society in the jurisdiction to which he has moved his practice.

SECTION 10. JURISDICTION. It shall be the policy of this Association and its component county medical societies that its members shall belong to the component county medical society having jurisdiction of the county of their predominant practice. When no such component county medical society has jurisdiction of the county in which a member has his dominant practice, such member shall belong to a component county medical society having jurisdiction of a county adjacent to the county in which the MEMBER has his dominant practice. This shall not necessarily be retroactive.

SECTION 11. The words "full-time" wherever used in this Chapter shall mean that no time at all is devoted to private practice.

CHAPTER II. General Meetings

SECTION 1. The general meetings shall be open to all members and guests who have complied with the registration requirements. These meetings shall be presided over by the President or a Vice-President.

SECTION 2. The program for the general meetings shall be prepared by the Council of the Medical Association of Georgia and approved by Council at least sixty days before the annual session of the Association and published in an issue of the *Journal* preceding the Annual Session.

SECTION 3. All papers read before meetings shall be deposited with the Secretary or the presiding officer and shall become the property of the Association. Without an acceptable excuse, failure to comply with this and other rules as regards the Annual Session as set forth by the Council shall automatically prohibit a member from participating in scheduled scientific sessions for a period of not less than five years.

SECTION 4. The general meetings shall be open to all registered members. Distinguished lay persons and guest physicians may be invited as special guests of the Association by the President or by action of Council.

SECTION 5. LOCAL ARRANGEMENTS COMMITTEE. As soon as practicable following the close of each Annual Session the component society which will act as host at the next Annual Session shall elect Local Arrangements Committees which shall recommend suitable meeting places and shall have general charge of all local arrangements subject to the approval of Council.

CHAPTER III. House of Delegates

SECTION 1. MEETINGS. The House of Delegates shall meet during the Annual Session at a time and place fixed by Council. The House of Delegates may also meet in interim sessions and at such other times as may be necessary for the transaction of the business of the Association.

SECTION 2. Each component county society shall elect one delegate and a corresponding alternate, each of whom has been a member in good standing for the prior three years, for each 25 members, or fraction thereof, whose dues have been paid by December 31st of the preceding year, provided that each component county society shall be entitled to at least one delegate. Delegates to the House of Delegates shall serve for a term of three years; one-third of the members of the House of Delegates to be elected annually provided that the component county societies which are entitled to three or more delegates shall elect at their first election, one-third of their delegation for a term of one year, one-third of their delegation for a term of two years, and one-third of their delegation for a term of three years and thereafter elect such delegates whose terms of office expire therewith. Those component county societies which are entitled to less than three delegates shall elect their delegate or delegates for staggered terms in rotation as may be determined by Council until one-third of the House of Delegates is being elected annually.

SECTION 3. Forty of the registered members of the House of Delegates shall constitute a quorum. All sessions of the House of Delegates shall be open to the members of the Association, except when in executive session.

SECTION 4. The House of Delegates shall be presided over by the Speaker or, in his absence, by the Vice-Speaker. In the absence of both, a delegate agreeable to it may preside. The Speaker and the Vice-Speaker shall be elected by the members of the House of Delegates and shall serve for a term of three years.

SECTION 5. The Secretary of the Association shall be the Secretary of the House of Delegates or, in his absence, a delegate appointed by the Speaker of the House of Delegates shall serve as Secretary of the House of Delegates.

The Executive Secretary may serve in this capacity.

SECTION 6. The following shall be the general order of business at all meetings of the House of Delegates: 1. call to order by the Speaker; 2. roll call; 3. election of Speaker and Vice-Speaker (every third year at second session of House of Delegates during Annual Session; their terms of office to begin with adjournment of the House of Delegates; provided a Speaker and Vice-Speaker be elected as the next order of business after the adoption of this Bylaw; 4. reading and adoption of minutes; 5. reports of officers; 6. reports of committees; 7. unfinished business; and 8. new business.

At any meeting, the House by majority vote may change the order of business. New business may be introduced at the final meeting of the House of Delegates only when such business is of an emergency nature or introduced by unanimous consent.

SECTION 7. For the purpose of expediting proceedings, the Speaker of the House of Delegates shall appoint from members of the House of Delegates the reference committees, the credentials committee, and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in debate, but shall not have the right to vote.

SECTION 8. All reports and resolutions shall be referred to the appropriate reference committees before action is taken by the House of Delegates.

CHAPTER IV. Council

SECTION 1. COMPOSITION. The Council is composed of the President, the President-Elect, the Immediate Past President, two Vice-Presidents, the Secretary, Speaker of the House of Delegates or the Vice-Speaker of the House of Delegates and one Councilor or Vice-Councilor from each Councilor District. Vice-Councilors shall be ex-officio members of Council, without the right to vote, except in the absence of their respective Councilors when they shall serve as Councilor. The Vice-Speaker shall be an ex-officio member of Council without the right to vote except in the absence of the Speaker when he shall serve in the Speaker's stead. The Treasurer, Editor of the *Journal*, Executive Secretary, and delegates to the AMA shall be ex-officio members of Council without the right to vote.

SECTION 2. CHAIRMAN AND SECRETARY. A Chairman and a Vice-Chairman of Council shall be elected annually at the organizational meeting and shall serve for one year, or until their successors are elected. The Chairman or Vice-Chairman shall preside over meetings of Council and appoint all necessary committees of Council. The Secretary of the Association shall serve as Secretary of Council. The Council may designate the Executive Secretary or Assistant Executive Secretary to serve in this capacity.

SECTION 3. EXECUTIVE COMMITTEE. The Council shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, who shall serve as Chairman of the Executive Committee, the President-Elect, the Immediate Past President, the Secretary, the Chairman of the Executive Committee, who shall serve as Vice-Chairman of the Committee, and the Chairman of the Council Committee on Finance. It shall meet monthly between the meetings of Council. At any duly called meeting of this committee for which proper notice has been given, any three (3) members of the committee shall constitute a quorum. The Committee shall make such recommendations to the Council and shall carry out such items of business as are referred to it by Council. The Executive Committee shall appoint all committee chairmen and committees of the Association

and nominate members of all Boards required by the laws of the State of Georgia on recommendation of the district societies where applicable; not otherwise provided for, subject to confirmation by Council, and shall serve as Publications Committee of the *Journal*. The Executive Committee shall recommend to Council the terms of employment and salaries of all personnel necessary to conduct the affairs of the Association. The Executive Committee shall be empowered to select an Executive Secretary who shall be responsible to the Executive Committee for his action and for the operation of the Headquarters Office, subject to the approval of Council. The Executive Committee shall act as a Board of Trustees directing the Executive Secretary in carrying out the mandates and policies of the Council and the House of Delegates. Between meetings of the Executive Committee, the Chairman of the Executive Committee of Council or his duly appointed representative shall direct the Executive Secretary as to undetermined matters of policy.

SECTION 4. MEETINGS. The Council shall meet at the close of the Annual Session to organize and at intervals of not more than four months until the next Annual Session. Special meetings of the Council may be held on the call of the President or upon the request of three members of Council. Regular meetings of Council will be held on call of the Chairman.

SECTION 5. GENERAL DUTIES. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and Bylaws. The Council shall provide such headquarters for the Association as may be required to conduct its affairs. The Council shall by appointment fill any vacancy in office not otherwise provided for, which may occur during the interval between Annual Sessions of the Association. The appointee shall serve until his successor has been elected and installed.

The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the Annual Session. The Council, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it without restriction for the good of the Association.

SECTION 6. SPECIFIC DUTIES. The Council shall determine the employment and salaries of all personnel necessary to conduct the affairs of the Association on the recommendation of the Executive Committee of Council. The Council shall control and direct all Association publications.

SECTION 7. BOARD OF CENSORS. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members whether in relation to other members, to the component societies or to the Association referred to it by the Association's Professional Conduct Committee. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any member of the Association or upon the request of the party concerned on which an appeal is taken from the decision of the Association's Professional Conduct Committee. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society or the Association's Professional Conduct Committee. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

SECTION 8. COUNCILOR AND VICE-COUNCILOR DUTIES. Each Councilor shall be organizer, peacemaker, and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in the betterment of, the component societies

in his district. He shall make an annual report of his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the Annual Session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties. He becomes a voting member of the Council only in the absence of the Councilor from his district.

SECTION 9. COMMITTEE ON FINANCE. The Chairman of the Council shall appoint from among its members a committee of three members to be known as the Committee on Finance, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the fiscal year beginning January 1st after each Annual Session. This proposed budget shall be prepared by the Committee on Finance for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

All expenditures made by the Local Arrangements Committee in connection with the Annual Session must be authorized in advance by the Committee on Finance. Council shall have control of all commercial exhibits at the Annual Session shall be met by Council on recommendation annual session shall be met by Council on recommendation of the Committee on Finance.

CHAPTER V. Election of Officers

SECTION 1. ELECTION. The President-Elect, two Vice-Presidents, Secretary, Councilors, and Vice-Councilors shall be elected by ballot by the members of the Association during the Annual Session. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. The Speaker of the House of Delegates and Vice-Speaker of the House of Delegates shall be elected by members of the House of Delegates and shall serve for a term of three years. Other officers shall be elected for terms of one year each except the Secretary, Councilors, and Vice-Councilors who shall serve for three years. No member shall hold the office of Secretary or Speaker more than two consecutive terms.. One-third of the Councilors and Vice-Councilors shall be elected annually.

SECTION 2. NOMINATIONS. Nominations for these officers except the Speaker and Vice-Speaker and the Councilors and Vice-Councilors shall be made orally from the floor as the last order of business at the first general session of the Annual Session and no nominating or seconding speech shall exceed two minutes. Nominations for Speaker and Vice-Speaker shall be made by members of the House of Delegates orally on the floor of the House of Delegates as provided in the House of Delegates order of business. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the Annual Session. If no nomination is presented by a district society in this manner, nominations shall be made from the floor.

SECTION 3. METHOD. The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes

shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SECTION 4. TIME. Voting shall take place during the hours of the scientific program up to the beginning of the last meeting on the last day of the Annual Session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.

SECTION 5. Delegates and alternates to the American Medical Association shall be elected in the same manner and at the same time and in accordance with the Constitution and Bylaws of the American Medical Association.

CHAPTER VI.

Rights and Duties of Officers

SECTION 1. PRESIDENT. The President shall (A) preside at all general meetings of the Association; (B) address the opening general session of the Annual Session; (C) assist the Councilors in improving the county and district societies as far as practicable; (D) serve as a member of Council and as a member of the Executive Committee; (E) serve as a member of all committees of the Association with the authority of all committees of the Association with the authority to call a meeting of any committee when necessity demands it or after failure of the chairman to do so. With the approval of Council, he may terminate any committee whose function has been fulfilled or replace any member of any committee who fails to show interest in performing the duties assigned to him; and (F) he shall be an ex-officio member of the House of Delegates without the right to vote.

SECTION 2. PRESIDENT-ELECT. The President-Elect shall be a member of the Council and of its Executive Committee, and shall be a member ex-officio without the right to vote, of all standing committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and, when possible, the standing committees. He shall be an ex-officio member of the House of Delegates without the right to vote.

SECTION 3. THE VICE-PRESIDENTS. The Vice-Presidents shall be members of the Council. The Vice-Presidents shall assist the President in the discharge of his duties. Upon request or in the absence of the President, the Vice-Presidents will preside over the general meetings of the Association in rotation. In the event of the President's death, resignation, or inability to serve, the Vice-Presidents, in their order shall succeed him for the unexpired term. The Vice-Presidents shall be ex-officio members of the House of Delegates without the right to vote.

SECTION 4. SECRETARY. (A) The Secretary and the Executive Secretary shall attend the general meetings of the Association and the meetings of the House of Delegates. The Secretary shall keep the minutes of their respective proceedings. At the request of the Secretary, the Executive Secretary may serve in this capacity. The Secretary, or upon his request, the Executive Secretary, shall be Secretary of the Council and its Executive Committee. The Secretary shall be an ex-officio member, without the right to vote, of the House of Delegates and all committees of the Association.

SECTION 4. (B) The Secretary and/or Executive Secretary, under the direction of the Executive Committee of Council, shall be custodian of all Association record books and papers, conduct the official correspondence of the Association, maintain membership records, issue membership cards, and provide for the registration of members at Annual Sessions.

The Secretary shall collect the regular per capita assessment from the component societies and shall make all required reports to the American Medical Association.

SECTION 5. IMMEDIATE PAST PRESIDENT. The Immediate Past President shall serve for one year immediately following

his term of office as President. He shall serve on the Council and its Executive Committee and shall be an ex-officio member of the House of Delegates without the right to vote.

SECTION 6. SPEAKER. The Speaker of the House of Delegates shall serve for three years after being duly elected by the members of the House of Delegates and he shall preside over all meetings of the House of Delegates. He shall also serve as a member of the Council concurrent with his term of office. It shall be his duty to preserve order and to follow the proper parliamentary procedures. It shall be the duty of the Speaker to have the representation of each component county society checked by the Committee on Credentials at the time of the Annual Session, and to fill such vacancies by appointment. Such temporary appointees shall be members of the component society having the vacancy. He shall appoint the House of Delegates Reference Committees and Credentials Committee.

SECTION 7. VICE-SPEAKER. The Vice-Speaker of the House of Delegates shall serve for three years after being duly elected by the members of the House of Delegates and he shall preside over the House of Delegates in the absence of the Speaker. The Vice-Speaker shall be an ex-officio member of the Council without the right to vote except in the absence of the Speaker when he shall serve in the Speaker's stead. In the event of the Speaker's death, resignation or inability to serve, the Vice-Speaker shall succeed him for the unexpired term.

CHAPTER VII.

Component County Societies

SECTION 1. COUNTY SOCIETIES. All county societies now in affiliation with the Medical Association of Georgia or those hereafter organized in this state which have adopted principles of organization in conformity with this Constitution and Bylaws may receive charters from the Association, provided that their constitution and bylaws shall have been submitted to the Council and received its approval in this regard. A component society shall consist of five or more active members.

SECTION 2. CHARTER. Council shall provide and issue charters to county medical societies organized to conform to this Constitution and Bylaws. Such charters shall be signed by the President and the Secretary. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws. Only one component county society shall be chartered in each county.

SECTION 3. NAMES OF SOCIETIES. The name and title of each component county society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of the Medical Association of Georgia.

SECTION 4. CUSTODY OF CHARTER. The charter of each component county society as issued by the Medical Association of Georgia, shall be preserved and shall be in the custody of the Secretary of such society at all times.

SECTION 5. PURPOSES. Each component county society shall promote the science and art of medicine and the betterment of public health in the county, and its influence shall be constantly exerted for bettering the scientific, moral, and material conditions of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every acceptable and eligible physician in the county or counties in its jurisdiction.

SECTION 6. DUTIES. Each component county society shall meet the following five minimum standards: Each society shall (1) meet a minimum of four times a year, elect officers and delegates annually at a meeting before January 1st, and report these officers to the headquarters office before January 1st; (2) maintain an up-to-date constitution and

bylaws in conformity with the Constitution and Bylaws of the Medical Association of Georgia and shall transmit a copy of its constitution and bylaws to the headquarters office for record; (3) maintain a Board of Censors and/or a Mediation Committee; (4) maintain minutes of each meeting in a permanent record book that will be available at all times; and (5) maintain scheduled programs at its minimum four meetings annually.

SECTION 7. DELEGATES. Each component county society shall elect at its annual meeting prior to January 1st delegates and alternates to the House of Delegates in accordance with these Bylaws. The Secretary of each component society shall send a list of such delegates to the Secretary of the Association before January 15th. In the absence of, or the disability or disqualification of a delegate, the vacancy may be filled by the President of the society from other members of the same component society, provided such vacancy is filled prior to the first session of the House of Delegates.

SECTION 8. COMBINED COUNTIES. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies. These societies when chartered shall be entitled to all the rights and privileges provided for component societies. A physician residing in a county not having a component society shall be referred to an adjacent component county society by Council.

SECTION 9. ANNUAL MEETING. Each component county society shall designate a meeting held prior to January 1st as its annual meeting at which time officers and delegates for the next year shall be elected and their names forwarded before January 15 to the Secretary of the Association.

SECTION 10. DISTRICT SOCIETIES. District societies shall have one or more meetings during the year and shall nominate a Councilor and Vice-Councilor as provided in these Bylaws. These district societies shall be organized for the best interests of the medical profession in Georgia and shall not necessarily conform with the boundaries of congressional districts. District societies shall elect officers, adopt a constitution and bylaws in conformity with the Constitution and Bylaws of the Medical Association of Georgia and levy dues for the government of its own affairs.

CHAPTER VIII.

Funds and Expenditures

SECTION 1. TREASURER. The Treasurer shall be appointed annually by the Executive Committee of Council subject to the approval of Council. The Treasurer shall be a member in good standing for at least three years prior to his appointment and may not be the same member who holds the office of Secretary. The Treasurer shall not be an officer of the Association but shall be an ex-officio member, without the right to vote, of Council and the House of Delegates. He shall be an ex-officio member, without the right to vote, of the Committee on Finance. The Treasurer shall give bond in such sum as may be fixed by the Council, the premium on such bond to be paid by the Association.

SECTION 2. TREASURER'S DUTIES. The Treasurer shall receive all funds of the Association together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at its last meeting of the fiscal year. The fiscal year includes the period of time from January 1st to December 31st inclusive. A financial report shall be published in the *Journal* as soon as practicable after the end of each fiscal year. All checks for Association expenditures shall be signed by both the Treasurer and the Secretary, or by any two officers of the Association designated by Council.

SECTION 3. DUES AND ASSESSMENTS. (A) The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the active members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The Secretary of each component county society shall cause to be collected and shall forward to the office of the Association before January 1st the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the headquarters office of the Association on or before April 1 shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the headquarters office of the Association. Neither shall the headquarters office of the Association receive payments of dues or assessments from anyone except the Secretary of the component county society or his representative.

An active member who fails to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears subject to reapplication and approval by his county society.

SECTION 3. (B) The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.

SECTION 3. (C) For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the Secretary of the component county society of which he is a member.

SECTION 3. (D) Any county society which fails to make the reports required before the annual session of the Association shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

CHAPTER IX.

Standing Committees

SECTION 1. The Standing Committees of the Association shall be as follows:

- (A) Committee on Legislation
- (B) Committee on Medical Education
- (C) Committee on Medical Defense
- (D) Committee on Professional Conduct
- (E) Committee on History and Vital Statistics
- (F) Committee on Public Health
- (G) Committee on Maternal and Infant Welfare
- (H) Committee on Rural Health
- (I) Committee on Industrial Health
- (J) Committee on Public Service
- (K) Committee on Cancer
- (L) Committee on Insurance and Economics
- (M) Committee on Veterans Affairs
- (N) Committee on Constitution and Bylaws
- (O) Committee on Scientific Exhibit Awards
- (P) Committee on Doman's Auxiliary
- (Q) Committee on Hospital Relations
- (R) Committee on Crawford W. Long Memorial
- (S) Committee on Mental Health
- (T) Committee on Geriatrics

SECTION 2. Unless otherwise provided in these Bylaws, each of these committees shall consist of three members, each of whom shall serve for three years. Unless otherwise provided in these Bylaws, Executive Committee of Council shall appoint standing committee members and standing committee

chairmen as needed. One member of each standing committee shall be appointed each year by the Executive Committee of Council to serve for three years. The Executive Committee shall make all appointments at least thirty days prior to the annual session and all standing committees shall hold their organizational meeting at the time of the Annual Session. The members of each committee shall serve staggered terms of office so that only one term shall expire each year. The President, with the approval of Council, may replace any member of any committee who fails to show interest in performing the committee duties assigned him. All committee chairmen shall make an annual report in writing to the Association headquarters office sixty days in advance of the Annual Session for consideration by the House of Delegates.

SECTION 3. (A) COMMITTEE ON LEGISLATION. The Committee on Legislation shall be composed of a chairman who shall have charge of matters pertaining to State of Georgia Legislation; a vice-chairman, who shall have charge of matters pertaining to legislation of the Congress of the United States, and three other members. The chairmen of the following committees shall serve as ex-officio members without the right to vote: Medical Education, Public Health, Maternal and Infant Welfare, Rural Health, Industrial Health, Insurance and Economics, Veterans' Affairs, Hospital Relations, and Mental Health. The President of the State Board of Medical Examiners and the Chairman of the State Board of Health shall also be ex-officio members of this committee without the right to vote.

The duties of the committee shall be to represent the Association in securing and enforcing State of Georgia and federal legislation as directed by Council, in the interests of public health and scientific medicine. The committee shall meet at least sixty days prior to the convened sessions of either the Georgia General Assembly or the Congress of the United States. The committee shall appoint at least ten key men, one from each congressional district to represent the committee in their area on matters pertaining to legislation of the Congress of the United States. As many other key men as are needed shall be requested to represent the committee on matters pertaining to State of Georgia legislation.

SECTION 3. (B) COMMITTEE ON MEDICAL EDUCATION. The Committee on Medical Education shall be composed of a chairman and two other members and the deans of the medical schools in the State of Georgia who shall serve in an ex-officio capacity without the right to vote. The committee shall consider and devise means of extending the educational work of the Association for the benefit of its members, working with the component societies whenever possible and serve for the Council on Medical Education of the American Medical Association in this State. The committee shall act as an advisory body in matters concerning medical education as directed by Council. All problems relating to the postgraduate study of medicine shall be referred to this committee.

SECTION 3. (C) COMMITTEE ON MEDICAL DEFENSE. The Committee on Medical Defense shall consist of five members of whom the Chairman of the Committee on Finance and the Secretary shall be members. The other members, one of whom shall be appointed chairman, shall be appointed by the Executive Committee of Council for terms of five years each. The duties of this committee shall be to investigate any claim of alleged malpractice made against any member upon the written request to the committee by said member. The committee shall, on the advice of counsel, in cases being worthy of defense, furnish the services of the Association counsel for the purpose of consultation and advice relative to threatened or actual litigation provided the Association does not assume financial obligation in excess of \$100.00 for any one member in any calendar year. Any charges or fees in excess of \$100.00 for any one member in any calendar year shall be borne by the member so request-

ing the privilege of medical defense consultation and advice as stated herein.

SECTION 3. (D) COMMITTEE ON PROFESSIONAL CONDUCT. The Committee on Professional Conduct shall consist of the five most recent Past Presidents of the Association. The senior member shall be chairman. It shall investigate all complaints relating to or involving the ethical or professional practice of any member of The Medical Association of Georgia. All complaints or accusations against any member of The Medical Association of Georgia relative to irregular practice, excessive fees, habitual failure to respond to calls without adequate reason, extravagant or questionable statements made as witnesses in a court of law, or any act calling for disciplinary measures or investigations of a member, shall become the concern of this committee. Complaints may be made by an individual patient, physician, board of censors of any local medical society, attorney, or any officer of a regularly constituted court of law. Upon receipt of notice of such complaint, the committee, through its individual members or some competent person designated by it, shall immediately investigate the charges, and if the committee is convinced that there is sufficient justification for a hearing the physician shall be requested to appear before at least three members of said committee to answer charges. Such hearing shall be conducted in private and the source of information and charges will be divulged only at such hearing. No member of this committee shall sit in a hearing involving a physician from his councilor district.

After deliberation, the committee shall have a choice of one of the four following dispositions:

1. Dismiss the case because of insufficient grounds for a legitimate complaint.
2. Attempt a satisfactory adjudication of the complaint.
3. Suggest to the physician changes in his conduct and relationship with his patients, in order that he may not bring unfavorable criticism upon his profession.
4. Refer to the Council of The Medical Association of Georgia all cases in which action by the Council is deemed necessary, together with recommendations as to disciplinary measures to be taken by the Council of The Medical Association of Georgia.

Nothing in this Bylaw shall be construed to prevent the selection and active participation in all the functions enumerated above by each component county society.

SECTION 3. (E) COMMITTEE ON HISTORY AND VITAL STATISTICS. It shall be the duty of the Committee on History and Vital Statistics to stimulate and promote the preparation of suitable articles on the history of the Association and its members, and shall recommend their publication to *The Journal* of the Association. It shall prepare memorials for deceased members, and arrange for their publication. It shall also report to the House of Delegates all new and eligible physicians who were licensed in the State during the past year indicating those who have become members of the Association. The Editor of *The Journal* and the President of the State Board of Medical Examiners shall be ex-officio members of this committee.

SECTION 3. (F) COMMITTEE ON PUBLIC HEALTH. The Committee on Public Health shall be composed of a chairman and four members and a member of the Georgia State Department of Public Health to serve in an ex-officio capacity in this committee. It shall be the duty of the Public Health Committee to meet at least annually and to act as a "clearing house" for any matter concerning Public Health. It shall also be the duty of the Public Health Committee to correlate their activity with the Georgia Department of Public Health.

SECTION 3. (G) COMMITTEE ON MATERNAL AND INFANT WELFARE. The Committee on Maternal and Infant Welfare shall be composed of three or more general practitioners, three or more obstetricians, and three or more pediatricians. Terms of office shall be for a period of three years with one-third

of the members appointed annually by the Executive Committee of Council. The committee shall regularly review and analyze the causes of all maternal deaths and perinatal losses occurring in the State for the purpose of recommending improvement. It shall also investigate conditions affecting maternal and infant care in Georgia and make recommendations concerning improvements thereof. The committee shall meet a minimum of twice annually.

SECTION 3. (H) COMMITTEE ON RURAL HEALTH. The Committee on Rural Health shall concern itself with improving medical service in the more sparsely settled areas in the State. It shall be composed of one member from each of the councilor districts comprising the Association as appointed by the Executive Committee of Council, and in addition, a member of the State Department of Public Health who shall serve as a member ex-officio without the right to vote. It shall investigate and make recommendations as to locating and staffing health centers and shall cooperate with the Better Health Council of Georgia, and the Council on Rural Health of the American Medical Association.

SECTION 3. (I) COMMITTEE ON INDUSTRIAL HEALTH. The Committee on Industrial Health shall be composed of five members. The committee shall confer with both labor and management in stressing the importance of preventive rather than curative medicine. It shall investigate and make recommendations concerning the initiation of programs designed to improve safe working conditions for employees and to solve other industrial health problems. It shall cooperate in all respects with the Council on Industrial Health of the American Medical Association.

SECTION 3. (J) COMMITTEE ON PUBLIC SERVICE. The Committee on Public Service shall be appointed by the Executive Committee of Council. It shall be the duty of the committee to integrate and publicize all approved plans and projects emanating from the Council and other standing and special committees of the Association. It shall consider all policies and make suggestions and recommendations for improving or changing such policies for the purpose of integration and publicizing. It shall develop additional projects for bettering understanding between physicians and the public.

SECTION 3. (K) COMMITTEE ON CANCER. The Committee on Cancer shall consist of one representative from the Association, one from each of the State-Aid Cancer Clinics, and one each from the medical colleges in the State who shall serve not less than three years, and the President shall appoint the chairman from among the members having the longest service. The chairman shall submit a list of physicians' names representing these groups for appointment by the President. An Executive Committee of this committee consisting of not less than six members shall be appointed by the President upon recommendation of the chairman.

It shall be the duty of this committee to represent the members of the Association in dealing with all matters pertaining to cancer, and in particular, it shall advise with the Division of Cancer Control of the Department of Public Health.

SECTION 3. (L) COMMITTEE ON INSURANCE AND ECONOMICS. The Committee on Insurance and Economics shall consist of not less than ten members, one from each councilor district, to be appointed for a period of three years in rotation by the Executive Committee of Council and the Executive Committee shall appoint one of these chairman. The chairman may nominate lay persons by the Executive Committee to serve in an advisory capacity.

SECTION 3. (M) COMMITTEE ON VETERANS' AFFAIRS. The Committee on Veterans' Affairs shall represent the Association in all matters pertaining to all veterans.

SECTION 3. (N) COMMITTEE ON CONSTITUTION AND BYLAWS. The Committee on Constitution and Bylaws shall recommend to the House of Delegates any amendments which seem to be necessary or advisable. Proposed amendments

shall be referred to this committee before action is taken by the House of Delegates.

SECTION 3. (O) COMMITTEE ON SCIENTIFIC EXHIBITS AND SCIENTIFIC AWARDS. The Committee on Scientific Exhibits and Scientific Awards shall have complete charge of all scientific exhibits and awards made by the Association or in the name of the Association for scientific exhibitors at the Annual Session.

SECTION 3. (P) COMMITTEE ON WOMAN'S AUXILIARY. The Committee on the Woman's Auxiliary shall cooperate with, advise, and direct the Auxiliary in all matters concerning the Association.

SECTION 3. (Q) COMMITTEE ON HOSPITAL RELATIONS. The Committee on Hospital Relations shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this state and shall, when indicated, confer with the State Department of Health, the Georgia Hospital Association, and all related organizations and make recommendations to this Association.

SECTION 3. (R) COMMITTEE ON CRAWFORD W. LONG MEMORIAL. The Committee on Crawford W. Long Memorial shall supervise matters pertaining to the Crawford W. Long Memorial and shall represent the Association in such matters subject to the approval of Council.

SECTION 3. (S) COMMITTEE ON MENTAL HEALTH. The Committee on Mental Health shall promote the welfare of the mentally ill in the State of Georgia and shall constantly seek means of improving care for the mentally ill in the State.

SECTION 3. (T) COMMITTEE ON GERIATRICS. The Committee on Geriatrics shall concern itself with the medical problems of the aged and chronically ill patient and pursue a continuing study of this problem as it affects the public health.

CHAPTER X.

Special Committees and Executive Secretary

SECTION 1. SPECIAL COMMITTEES. Special Committees may be created at any time when the necessity arises. Their necessity must be approved by the Council and they shall be appointed by the President. Such special committees shall be appointed annually and the term of office shall run concurrently with that of the appointing President.

SECTION 2. EXECUTIVE SECRETARY. The Executive Secretary shall be the administrative agent of this Association, of its Council, and of all its committees. He shall be the executive agent of the Association transacting its business under the direction of the Executive Committee of Council and shall be the directing manager of the headquarters office. He shall discharge the administrative functions of the Association not within the duties of the Association officers and committees and shall keep himself informed in regard to non-professional matters affecting the medical profession. He shall be responsible to the Executive Committee of Council for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council, and the officers of the Association.

The selection, terms of employment, and salary of the Executive Secretary shall be determined by the Executive Committee of Council, subject to the approval of Council. The Executive Secretary shall be responsible to the Executive Committee of Council and the Executive Secretary shall prepare a report on the activity and status of the headquarters office for the Executive Committee of Council at each of their meetings to keep the committee informed at all times.

CHAPTER XI.

The Journal

SECTION 1. *The Journal of the Medical Association of Georgia* herein referred to as *The Journal*, shall be under the

control and direction of the Council. It shall appoint an Editor and an Editorial Board annually and make any other provisions for the publication of *The Journal*; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

SECTION 2. The Council may employ a Business Manager of *The Journal* and other personnel and fix the terms of such employment.

SECTION 3. All papers presented before the Annual Session shall be submitted to the Editor for consideration for publication in *The Journal*. Abstracts of transactions of the House of Delegates and Council shall be published as early as practicable. Records and notices of component county and district society meetings may also be published, and consideration given to the publication of papers presented before such meetings.

SECTION 4. The Executive Committee of the Council shall constitute the Publications Committee of the *Journal*.

**CHAPTER XII.
Rules and Ethics**

SECTION 1. The Principles of Ethics of the American Medi-

cal Association, this Constitution and Bylaws as now set forth or as may be hereafter amended and the standards of the profession in Georgia shall govern the conduct of the members of this Association.

SECTION 2. The deliberations of the Association shall be conducted in accordance with parliamentary usage contained in the then current edition of Roberts' "Rules of Order, Revised," unless contrary to this Constitution and Bylaws.

**CHAPTER XIII.
Amendments**

These Bylaws may be amended at any Annual Session by a majority vote of the House of Delegates after the amendment has lain on the table for one day.

CHAPTER XIV.

On the adoption of this Constitution and these Bylaws all rules and regulations in conflict herewith, are hereby repealed, provided that all officers, delegates, and committeemen now in office shall continue their incumbency until their successors are duly elected and installed or chosen as herein provided.

MEDICAL ASPECTS OF CIVIL DEFENSE

MEGATON NUCLEAR DEVICES and missiles delivery weapon systems have radically changed concepts of warfare. The inevitable concomitant is radically changed concepts of emergency medical treatment. The increase in the destructive power of weapons means a correspondingly larger involvement of civilian populations in warfare. This larger involvement of civilian populations in any future war, which may unleash its massive destructive fury with warning time counted in but minutes, requires prior, cool, judicious planning and organization to minimize the effects of modern weapons. In these days of warlike co-existence for peace, there is urgent need for a suitable national plan that will offer the nation's people the best feasible protection against

nuclear weapons and the best possible disaster medical care.

Civil defense has been a concern of government since before World War II. In the Federal government, the responsibility, in varying degree, for civil defense over the years has reposed in many different agencies. Since 1950 with the creation of the Federal Civil Defense Administration, the first independent agency wholly concerned with civil defense, there have been plans for the medical care of stricken populations after enemy attack. Original plans were based on an A-bomb attack, (nominal or 20,000 ton TNT equivalent) and envisioned three echelons of service: (1) self-help, family-help, neighbor-help, and community-help; (2) mutual

assistance, or the support and aid that would come from the surrounding populace, for example, suburbs in the case of large cities; and (3) mobile reserve, or those units that would come a distance to give aid and succor to a stricken community. Medical care would follow three steps: (1) first aid, given either in the rubble, at collecting points in the field by field first-aid teams, or at the first-aid station; (2) emergency surgery at the 200-bed Civil Defense Emergency Hospital; and (3) definitive care at existing hospital and medical facilities.

National Emergency Medical Care Plan

As bombs became larger and weapon delivery systems speedier it was necessary to revise these plans considerably. Limitations of staff, inadequate facilities for securing vital data, urgency of daily operation, administrative problems, and a variety of other causes did not permit the staff of the then Federal Civil Defense Administration Health Office to engage in this type of necessary planning. As a consequence, on December 10, 1956, the Federal Civil Defense Administration requested the American Medical Association, through its Council on National Defense to undertake a study to establish criteria for the provision of medical care of the surviving population, casualty and non-casualty, in the event of an enemy attack on this nation. The proposal was presented to the Board of Trustees of the Association on February 9, 1957. The Board authorized the Council on National Defense to explore this proposal in detail. A formal contract between the United States Government, acting through the Federal Civil Defense Administration, and the American Medical Association was signed on July 26, 1957. In broad terms the contract specified that the Association should "study, develop, and recommend the planning, training, and operational organization needed as a basis for a National Emergency Medical Care Plan for the treatment and care of casualties and noncasualties prior to, during, and after a hypothetical 20 megaton ground burst thermonuclear attack upon a selected geographical area or areas of the United States."

Six Members Designated

To facilitate work on this project, the Association created the Commission on National Emergency Medical Care. The six members designated to serve on the Commission were Brigadier General Harold C. Lueth, MC, USAR, Chairman, Captain Carroll P. Hungate, MC, USNR, John F. Burton, M.D., Robert L. Novy, M.D., Colonel Karl R. Lundeberg, MC, USA, (Ret.), and Colonel Hanns C. Schwyzer, MC, USAR. Major General Earle Standlee, MC, USA, (Ret.) was named staff director. Three task forces on organization, emergency medical care, and personnel training and utilization, were created. Serving on these task forces were qualified and dedicated personnel from the health professions. Throughout the study, opinions were obtained from many of the national health agencies, the voluntary health associations, personnel in various branches of the government, from individuals, and from prior reports, studies, plans, and recommendations of many organizations, both governmental and nongov-

ernmental. From all these sources the Commission developed recommendations that can be used as a basis for a national emergency medical care plan.

During the period of the study there were significant accomplished changes in the government agencies concerned with civil defense affairs. Other changes have been proposed and are under study. On July 1, 1958 under the President's Reorganization Plan No. 1 of 1958, the Federal Civil Defense Administration and the Office of Defense Mobilization were consolidated to form the Office of Civil and Defense Mobilization in the Executive Office of the President. Former Governor of Iowa Leo A. Hoegh, who had been Administrator of the Federal Civil Defense Administration, was appointed Director of the new agency by the President. Another significant development was the proposed delegation by the President of certain responsibilities for civil defense health services to the Secretary of Health, Education, and Welfare for discharge by the United States Public Health Service under the policy guidance and direction of the Office of Civil and Defense Mobilization. Principally, this proposal concerns the responsibility for planning a nationwide health and medical care program dealing with the care of the civilian population in the event of an enemy attack. The American Medical Association favored these developments and was of the opinion that much ambiguity, uncertainty, and confusion of past organizational structure would be obviated.

Yet another important development was the promulgation by President Eisenhower in October 1958 of the National Plan for Civil Defense and Defense Mobilization. When completed by the addition of 40 operational annexes, all phases of civil defense operations will be covered. Annex No. 7, "Role of the Military," which is now ready for promulgation, will be of particular interest to military personnel. It sets forth the responsibilities of the Armed Forces of the United States in assisting civil authority in time of national emergency or other disaster.

The Association's Commission on National Emergency Medical Care completed its study in November 1958. After careful review by the Council on National Defense and other departments of the Association, the final report of the Commission was adopted by the Board of Trustees on February 24, 1959. The report was submitted to the Office of Civil and Defense Mobilization last month.

Developing criteria for planning, training, and operating a medical service that will give the greatest good to the largest number of people under the catastrophic conditions resulting from a thermonuclear burst of 20 megatons required bold thinking, resourceful planning, and radical care. All individuals and organizations that were requested to assist the Association in this unique and challenging task, did so with zeal and devotion. Their dedication is worthy of the highest praise.

The implications of nuclear attacks are so great that each physician, dentist, veterinarian, nurse, and health worker must prepare to give medical service of a type and scope that has never been done before. It would be well for all health workers, military and civilian, to give this matter their most serious consideration.

From the Council on National Defense of the American Medical Association. The views and opinions expressed are not necessarily those of the Department of Defense.—Editor.

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THE MECHANISM AND MEANING OF LIVER FUNCTION TEST

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THERE IS SOMETHING magnificently primitive about the liver that reminds one of our unicellular ancestors. The liver cell, like the amoeba, combines simplicity of structure with enormous complexity of function. Other cells of the body have only one kind of function. They depend on the supply of prefabricated components to pursue their stereotype activity. The liver cell can take in, build up, break down, and cast off. The liver is very much like a parasitic colony of unicellular parasites whose services are indispensable to its host. The cells are simple and low on the evolutionary scale. The colony itself is well defined by its anatomical boundaries, in its physiologic function, and its biologic properties, from the rest of the body. The liver has a unique feeding system—the portal vein. It has its own excretory system, the biliary tree, which empties through a cloaca, the ampulla, into the gut. In contrast to other tissues the liver, when mutilated, regenerates itself by its own specialized type of cells and can replace the lost part.

Because of the tremendous complexity of the biologic function of liver cells; because of the enormous regenerating power; and the great reserve capacity of this organ, no simple chemical test is available to evaluate the physiologic state of the liver. Disease processes, such as granuloma or neoplastic infiltration, which produce focal depletion of functioning units, will interfere little with a great many of the usual activities of the liver, since it has such a great reserve capacity that 80 per cent of the organ can be removed without serious consequences. On the other hand, diffuse interference

This organ of many functions provides many areas for testing.

with blood supply, outflow of bile, or metabolic activity may give early and significant alteration in many of its functions. Changes in the liver function tests are not dependent on, nor do they necessarily reflect specific clinically recognized disease entities. On the other hand, these tests describe some aspects of the physiologic state of the liver. For example, changes in the function tests produced by intrahepatic cholestasis—medical jaundice—are indistinguishable usually from those produced by extrahepatic obstruction—surgical jaundice. Recognizing this distinction would give the practicing physician less headache in attempting to derive a clinical diagnosis from laboratory procedures which evaluates the physiologic activities. The laboratory gives only part of the story which has to be fitted into the entire clinical picture, and it is up to the physician to make the diagnosis and not the laboratory technologist.

Of the large number of chemical procedures used to evaluate hepatic function it would be of interest to re-evaluate but a few at this time.

Bilirubin

It is fairly well established by now that the bilirubins present in plasma can be grouped into two separate groups. One, is a crystalline bilirubin, which reacts "indirectly" with the van den Bergh reaction; two, is the conjugated bilirubin. Bilirubin can be conjugated with various substances, such as glycine, sulfate, etc., but the most common substance with which bilirubin is conjugated is glucuronic acid. On

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the bilirubin molecules there are two places to which glucuronic acid can be connected. Thus, there are two glucuronide conjugates of bilirubin, the monoglucuronide and diglucuronide.

While crystalline bilirubin, as it forms from heme through biliverdin, gives the indirect reaction, the monoglucuronide will give both the direct and indirect reactions, since in the usual testing procedure the reagent reacts only with one-half of the bilirubin molecule. Diglucuronide or diconjugates of bilirubin in general will give only the direct reaction. It is of interest that the monoglucuronide can be conjugated outside of the liver. The diglucuronide is conjugated only within the liver cell. It was shown¹ that diseases characterized by obstruction of bile flow are associated with hyperbilirubinemia, where more than 50 per cent of the *direct* reacting bilirubin is bilirubin diglucuronide, as opposed to hyperbilirubinemia due to parenchymal liver cell injury, where more than 50 per cent of the *direct* reacting bilirubin is due to bilirubin monoglucuronide.

A similar phenomena was described recently regarding BSP. Like bilirubin, BSP is excreted by the liver as a conjugate. The measurements of total BSP retention, 45 minutes after the injection of 5 mg./kg., does not distinguish the various mechanisms producing jaundice. However, if, in addition to total BSP retention, BSP conjugates are also measured, one finds that the conjugation of BSP is more severely impaired in the presence of parenchymal liver cell injury than in the case of intra or extrahepatic obstruction. In one series of 60 patients, Carbone² and others, found that in the presence of obstructive jaundice over 40 per cent of the retained BSP is conjugated, while in the presence of cirrhosis and hepatitis, less than 17 per cent was conjugated at the end of 45 minutes. While the determination of the bilirubin and BSP conjugates today is only in the realm of the research laboratory, these procedures in the coming years will probably become available to the clinical laboratory and to the practitioner.

When radioactive iodine labeled cholographin is injected intravenously, it rapidly accumulates in the normal liver. The blood level will rapidly decline and the urinary excretion of the isotope labeled compound is low, while the fecal excretion is high. However, if the liver is diseased the accumulation of the isotope labeled compound in the liver is negligible and the urinary excretion will be higher therefore, because the blood level is higher and the fecal excretion is low. In studies performed by Dr. John McLaren,³ he showed that while there is a difference in the urinary and fecal levels of I-131 cholographin

between the normal and liver disease patients, there is a much more striking difference in the accumulation of this compound in the liver. We pursued a study of normal patients and patients with various liver diseases, following the injection of I-131 cholographin, by the accumulation of radioactivity in the liver as opposed to the amount of radioactivity counted over the heart. This accumulation then was expressed as a percentage increase or decrease of the equilibrium count rate. In our studies so far, there were distinct differences between the normal group and the liver disease groups in their ability to accumulate radioactivity in their liver following the intravenous administration of a tracer dose of I-131 cholographin. The mean value for patients with liver disease was minus seven per cent, and the calculated 95 per cent confidence limit was ± 5.3 . In the normal group, the uptake of radioactivity in the liver had a mean value of ± 21.7 per cent, with a lower limits of 95 per cent confidence limit of ± 11 per cent. Up to the present time we did not have an overlap of values in the two groups. In some instances this test has compared favorably with a BSP test in detecting correctly liver cell injury. I would anticipate, however, on the basis of our experience with other liver function tests, that some overlap may occur between these two groups when a large number of patients are studied. Administration of I-131 cholographin gives information regarding the ability of the liver to excrete a compound which can opacify the gallbladder. It can be used to detect liver cell dysfunction in patients in whom their intravenous cholangiography did not visualize the duct or the gallbladder. Or, conversely, on a basis of this test, one can predict which patient should have normal biliary tree visualization, following the administration of an adequate dose of inert cholographin, on the basis of hepatocellular function. Any abnormal visualization in these patients would then be attributable to intrinsic biliary tract disease.

Derangements of Protein Metabolism

The synthesis of plasma albumin, prothrombin, factor seven, factor five, fibrinogen, and possibly alpha globulin, takes place in the hepatic parenchyma. Probably some of the other protein constituents of plasma are also derived from this source; however, the site of origin of other serum globulins is not definitely identified. Probably they are manufactured in the reticuloendothelial system. In man, the greatest quantity of reticuloendothelial system, next to the bone marrow, is in the liver. In the presence of liver disease, (and, also in some other diseases), both quantitative and qualitative alterations occur in the various serum protein fractions. The quantitative changes are best reflected by serum electrophoresis. This method, however, does not describe

the qualitative changes within the various protein fractions. Numerous non-specific chemical procedures were described for the determination of some of these protein changes. The most time-honored and most widely used of these are the cephalin cholesterol flocculation and the thymol turbidity tests.

Let us examine the mechanism of these simple laboratory procedures as to how they reflect alterations in the serum proteins.

Cephalin Cholesterol Flocculation Test

The cephalin flocculation test (CCF) depends upon the balance of the stabilizing and flocculating forces in the serum. The stabilizing forces consist mainly of the labile lipid rich constituents of electrophoretically derived albumin and alpha-1 globulin fractions. Because of the instability of the stabilizing factors normal serum may become positive after prolonged standing on the laboratory bench or stored in the conventional refrigerator. The stabilizing factors decrease in the serum within 48 hours after acute parenchymal injury and remain low or absent until hepatic healing is well-established. Factors in the serum responsible for producing flocculation are the gamma globulins.

The positive CCF usually reflects morphologically acute necrotizing lesions in the hepatic parenchyma, especially those that incite mesenchymal irritation. The test does not indicate the extent of hepatic damage, nor does it become positive in all forms of hepato-cellular injury. The CCF reaction is not a true liver function test, though it is positive in 90 per cent of cases with hepatitis, and 70 per cent of cases with cirrhosis with cell necrosis, and 40 per cent of cases with cirrhosis without cell necrosis on the liver biopsy specimen. It is also positive in many of the collagen diseases, some cases of hemolytic jaundice, acute leukemias, but usually is negative in the presence of elevated gamma globulin due to chronic leukemia, Hodgkin's disease, and multiple myeloma. Its great usefulness is that it is negative in the presence of obstructive jaundice though it does not differentiate extrahepatic from intrahepatic cholestasis.

Thymol Turbidity Test

A thymol turbidity test depends also on a balance of various fractions of serum proteins. The stabilizing component is serum albumin; however, in this test the stabilizing factors do not play as important a role as they do in a CCF test. The turbidity producing components are, in addition to the gamma-globulins, the beta globulins, lipo-proteins, and serum lipids. Because of the great turbidity producing property of lipids, thymol turbidity was used for a so-called thymol turbidity tolerance test following a standard fat meal to measure fat absorption. It is essential that these procedures are to be performed

on a fasting patient. The extraction of lipids with ethyl ether will prevent turbidity. In acute hepatitis the thymol turbidity test is closely related to alteration of serum lipids, while in chronic hepatitis the relationship between thymol turbidity and gamma globulin is much closer. In infectious hepatitis the thymol turbidity becomes positive later than cephalin flocculation and will persist longer than the cephalin flocculation test. In fatty portal cirrhosis the CCF is more likely to be abnormal than the TT. On the other hand, in postnecrotic cirrhosis the TT is more likely to be abnormal than the CCF, although, in both conditions, both tests may become positive.

Thymol turbidity is not a specific liver function test either. It is likely to be elevated in many other diseases associated with high gamma globulin levels. There is one remarkable exception, however, and that is multiple myeloma.

From a clinical point of view, one of the greatest advantages of the CCF and TT tests is that they are negative in obstructive jaundice. In examining the forces which make a positive flocculation and turbidity test it is interesting to note that the very non-specificity of the tests makes them so very useful in the clinical laboratory. It is clear by now that changes in gamma globulin concentration of the serum alone is not the main determining factor for the positivity of the flocculation and turbidity tests. There are three main factors which account for variations in these tests:

1. Serum albumin (Table I): Increasing concentration of serum albumin will convert an originally positive to a negative test in vitro, and there is a stoichiometric relationship between the amount of albumin added and the increasing negativity of the

TABLE I
Variations in the Amount of Albumin Added to Constant Mixtures of Normal Serum and Gamma Globulin, and of Obstructive Jaundice Serum and Gamma Globulin

Serum (ml.)	Gamma Globulin* (ml.)	Albumin** (ml.)	CCF	TT
Normal				
0.5	0.3	0.10	4+	5.5
0.5	0.3	0.15	3+	5.1
0.5	0.3	0.20	3+	3.9
0.5	0.3	0.25	2+	3.1
0.5	0.3	0.30	2+	2.7
0.5	0.3	0.35	1+	2.6
0.5	0.3	—	4+	7.4
Obstructive Jaundice				
0.5	0.3	0.10	2+	6.8
0.5	0.3	0.15	1+	4.1
0.5	0.3	0.20	1+	3.7
0.5	0.3	0.25	(—)	2.1
0.5	0.3	0.30	(—)	1.9
0.5	0.3	0.35	(—)	1.7
0.5	0.3	—	3+	10.8

* 3 per cent solution.
** 25 per cent solution.
(modified from Ducci)¹

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test. It is of great interest, however, that the same amount of albumin from a patient with infectious hepatitis will have much less influence on the stabilizing ability of this albumin of a positive serum, than albumin has when isolated from a normal individual. In other words, a 4+ CCF test is converted to negative by the addition of 0.4 cc. of normal serum albumin and this 4+ CCF may become only 3+ or 2+ when 0.4 cc. of serum albumin is added from a patient with infectious hepatitis. The stabilizing ability of serum albumin, obtained from patients with cirrhosis has even lesser stabilizing effect than serum albumin obtained from patients suffering from infectious hepatitis. The effect of these albumins on TT is less marked than their effect on the CCF test.

2. The second factor responsible for the production of turbidity and flocculation is gamma globulin (Table II): The addition of increasing amounts of gamma globulin to originally normal serum will produce increasing positivity of the flocculation test, and increasing turbidity in the TT test. It is of interest that gamma globulin obtained from patients with hepatitis or cirrhosis will have a much more potent flocculation and turbidity producing ability than gamma globulin obtained from normal individuals. Thus, in the flocculation and TT tests the qualitative as well as the quantitative changes in serum albumin and gamma globulin play a very fundamental role.

3. There is a very important third factor which makes these tests even more helpful in the differentiation of primary parenchymal disease versus obstructive biliary disease. There is an unknown factor in the serum of patients with biliary obstruction which has a depressive effect on the turbidity of

flocculation reactions (Tables I, II), and has been demonstrated beautifully by Ducci⁴ and many others. While the addition of normal human gamma globulin to normal serum will produce from negative to one, two, three, and four plus of CCF and increasing TT, the addition of the same amount of gamma globulin to the same amount of serum obtained from a patient with extrahepatic obstruction, does not produce "abnormal" CCF and the increase of the TT is smaller. Also, if, to a constant mixture of serum and gamma globulin increasing amounts of albumin are added, it is clearly demonstrable that much less albumin is needed to produce a negative CCF and normal TT, if the serum in the mixture is from a patient with obstructive jaundice than if from a normal individual. Thus, albumin has a more potent stabilizing effect in the presence of obstructive jaundice serum than in normal serum, and gamma globulin is much less effective in producing flocculation and turbidity in the presence of obstructive jaundice serum as compared to normal serum.

The factor or factors responsible for the inhibition of flocculation and turbidity reactions in obstructive jaundice serum are not well known. It is, however, of great interest that obstructive jaundice serum has a peculiar inhibitory effect on an apparently more specific reaction. Recently, Dr. Haven⁵ introduced a hemagglutination test for the diagnosis of viral hepatitis. He demonstrated the antigen, possibly the hepatitis virus, in volunteers inoculated by known icterigenic serum. The addition of obstructive jaundice serum to a positive agglutination mixture will have a powerful inhibitory effect on the hemagglutination tests. He demonstrated that the size of the molecule responsible for this inhibition is much larger than the size of the molecules responsible for the hemagglutination test. Whether the factors responsible for the inhibition of the hemagglutination of viral hepatitis are the same as the factors responsible for the inhibition of the CCF and TT tests remains to be seen.

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TABLE II

Addition of Normal Gamma Globulin in Increasing Amounts to Normal and Obstructive Jaundice Sera

Serum (ml.)	Gamma Globulin* (ml.)	CCF	TT
Normal			
0.5	0.05	1+	6.0
0.5	0.10	1+	6.0
0.5	0.15	2+	8.7
0.5	0.20	3+	11.2
0.5	0.25	3+	13.3
0.5	0.30	4+	14.6
0.5	—	(—)	3.9
Obstructive Jaundice			
0.5	0.05	(—)	4.6
0.5	0.10	(—)	5.5
0.5	0.15	(—)	7.9
0.5	0.20	(—)	8.5
0.5	0.25	(—)	9.9
0.5	0.30	1+	10.8
0.5	—	(—)	3.9

* 3 per cent solution.
(modified by Ducci)⁴

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RESPIRATORY ARREST FOLLOWING THE ADMINISTRATION OF NEOMYCIN

Neostigmine has been noted to raise the threshold for neomycin induced respiratory arrest.

ONE OF THE MOST valuable contributions to modern surgery has been the advent of antibiotic therapy. But at the same time, there has been a proportional increase in the associated complications. At present, more than 3,000 antibiotic agents have been investigated but less than two dozen are in commercial production. One of the most difficult demands on the performance of an antibiotic is that the material possess a minimum of toxicity within the dose range needed for effective use. Occasionally a particular toxic manifestation will not become obvious until the drug has been in common use for some time.

In 1949, Waksman and Lechevalier,¹ working with soil microorganisms, derived an antibiotic which they called neomycin. This drug exhibits a broad and effective spectrum of antibacterial activity, but because of the nephrotoxicity and ototoxicity associated with parenteral administration, it has been employed for the most part as an intestinal antiseptic and as a topical antibiotic.

In 1956, a third striking toxicity of neomycin therapy was emphasized by Pridgen,² who reported four cases of respiratory arrest which he attributed to the use of intraperitoneal neomycin. A total of 14 cases of neomycin induced apnea have been reported in the literature, and in five of these cases the patient died. In each instance, neomycin had been used to combat peritoneal contamination and was considered responsible for the respiratory arrest. Pittinger and Long³ have suggested that the underlying cause of the apnea referred to by these clinical reports was probably a curare-like activity of neomycin producing a blockade of the neuromuscular junction with subsequent paralysis. They also suggest⁴ that this effect is potentiated when ether,

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which has a similar property, is the anesthetic agent.

The present study was undertaken to determine whether neomycin effects a central respiratory depression as well as neuromuscular blockade and whether peritoneal trauma alters absorption of intraperitoneally administered drugs sufficiently to be a significant factor in the production of lethal serum levels. Experiments to confirm the reports of neostigmine antagonism to neomycin-induced respiratory arrest were also carried out.

Methods

Adult mongrel dogs weighing seven to ten kilograms were anesthetized with 70 mg./kg. chloralase prepared as a five per cent solution in ten per cent urethane. (Chloralase does not depress respiration except late in the course of anesthesia, and leaves the cardiovascular system relatively unaffected. Urethane was used primarily to enhance chloralase solubility but it also produces a narcosis in animals without significant depression of respiration, circulation, or spinal reflexes.) The animals with contaminated peritoneum were prepared by percutaneous injection of a fecal saline mixture into the cavity. Test injections into these animals were made after eight to 12 hours. Electrocardiograms and blood pressures were recorded on an eight-channel Grass electroencephalograph. Respiratory rate and volume were measured by means of a micro canine respirometer. Test doses of neomycin sulfate in saline solution were injected intravenously, intraperitoneally, and intratracheally. Samples of venous blood and cerebrospinal fluid were taken at intervals of 5, 10, 20, 40, and 80 minutes following a

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test injection or at time of death, if such occurred. Each animal served as its own control. Plasma and cerebrospinal fluid neomycin levels were determined by turbidometric bio-assay utilizing *E. coli* and *B. subtilis* as test organisms. The method consisted of comparing two-fold dilutions in tryptose phosphate broth of a known amount of neomycin dissolved in control serum or cerebrospinal fluid obtained from the subject, with similar preparation of the test fluid in which the neomycin concentration was to be determined. Both sets of tubes were inoculated with a test organism of known age, volume, and dilution. The concentration of neomycin in the test fluid was calculated by multiplying the concentration of neomycin that would inhibit the test organism by the dilution of the test fluid that gave the same inhibition.

Results

In order to determine whether neomycin effects central respiratory depression as well as peripheral neuromuscular blockade, three phases of investigation were made. Cerebrospinal fluid was examined for neomycin buildup after developing high neomycin levels in the peripheral blood. Neomycin was then injected intrathecally. Following a large intravenous dose of neomycin the phrenic nerve was monitored for altered frequency of discharge during the induced apnea.

(1) Each of four dogs were injected intravenously with 175 mg./kg. neomycin and developed immediate apnea. The average plasma level attained at this dose was 300 mcg./ml., while cerebrospinal fluid samples obtained during the period of apnea assayed consistently less than 0.625 mcg./ml.

(2) Two dogs received cisternal injections of neomycin in amounts sufficient to develop cerebrospinal fluid concentrations up to 500 mcg./ml. This procedure caused occasional emesis but no depression of respiratory rate of volume.

3) The discharge frequency of the phrenic nerve was monitored in two dogs while respiratory arrest was induced by 175 mg./kg. neomycin injected intravenously. There was no decrease in frequency of discharge when apnea occurred and an increased discharge frequency was noted as anoxia ensued.

Neostigmine antagonism to the curare-like activity of neomycin was investigated in three dogs. The minimum intravenous dose of neomycin required to produce apnea was found to be approximately 50 mg./kg. At this dose, the duration of respiratory arrest was 20 to 30 minutes. Neostigmine methylsulfate was given intravenously in doses of 50-100

mcg./ml. one to two minutes prior to the injection of neomycin and was found to elevate the dose needed to produce apnea by approximately 20 per cent. Pretreatment with neostigmine was noted to decrease the duration of respiratory arrest by approximately one-third.

The possibility that peritoneal trauma could allow a more rapid development of lethal serum levels through an increased rate of absorption was considered. In four dogs with normal peritoneum, 200 mg./kg. of neomycin injected intraperitoneally caused no respiratory arrests. The maximum neomycin blood level attained in these animals was 100 mcg./ml. occurring 30 to 40 minutes after injection. An equal number of dogs were subjected to peritoneal contamination with a fecal saline mixture and eight to 12 hours later received 200 mg./kg. neomycin intraperitoneally. Each of these animals developed respiratory arrest 10 to 20 minutes after receiving the neomycin. The average blood level at the onset of apnea was 200 mcg./ml. Four dogs without damaged peritonei were given 400 mg./kg. neomycin intraperitoneally. Two of these animals developed apnea 30 minutes following injection with peak blood levels of 200 mcg./ml. Maximum blood level in the two dogs which did not develop respiratory arrest never exceeded 100 mcg./ml.

Respiratory arrest of prolonged duration, accompanied by persistent elevation of the neomycin blood levels, was noted to occur in two animals which developed an unexplained hypotension.

Summary

A report on a study of neomycin toxicity has been presented. It is concluded that neomycin does not cross the blood-brain barrier in any appreciable concentration and effects no central respiratory depression. Peritoneal damage allows for a more rapid absorption of the drug and definitely lowers the minimum lethal dose when used under such conditions. Neostigmine has been noted to elevate the neomycin dose necessary to produce respiratory arrest and shorten the duration of the induced apnea. Hypotensive conditions have been observed to intensify neomycin toxicity, probably through decreased glomerular filtration.

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The neomycin used in this study was supplied by the Upjohn Company, Kalamazoo, Michigan.

This report was presented at Surgical Fundamental Forum of American College of Surgeons, Chicago, Illinois, October, 1958.

COMPLICATIONS OF GALLSTONES

PIERPONT F. BROWN, JR., M.D. AND PIERCE K. DIXON, JR., M.D., *Gainesville*

*Postoperative complications were three times more frequent
in the cases with biliary complications.*

GALLSTONES CAN PRODUCE serious complications that tend to increase the morbidity and mortality of a disease which so frequently is regarded as benign and innocent. The recognition of cholelithiasis in early adult life permits the performance of cholecystectomy under the most favorable conditions and before the development of acute cholecystitis, common duct stones, carcinoma, and the other serious complications of gallstones. The incidence of gallstones with complications increases with advancing age, when the incidence of cardiovascular, pulmonary, and renal disease is high. This is a major factor contributing to the mortality of biliary tract surgery. Biliary tract surgery is the most frequent type of abdominal surgery performed in the elderly patient.^{1,2} The purpose of this paper is to discuss the complications of gallstones, and how they contribute to the morbidity and mortality of biliary tract surgery.

This study is based on 237 consecutive cholecystectomies performed on one surgical service in a six-year period, January 1953 to January 1959. One hundred fifty-seven of these were elective procedures, and 80 were emergency cholecystectomies for acute cholecystitis. All of the acute cases represented serious complications of gallstones; but, in addition, many of the elective cases presented important complications such as common duct stones, enteric fistulas, etc. There are numerous complications of gallstones, and the list in Table I is intended as a single classification. Many of the cases of our series had several of the complications co-existing.

Chronic Cholecystitis with Cholelithiasis

We had 157 patients with chronic disease who had elective cholecystectomies. There was no mortality in this group, again emphasizing the impor-

tance of early surgery for gallstones. The typical patient, described as fair, fat, and 40 with right upper quadrant pain, is easily recognized. However, this typical picture may be changing. It is now thought that gallstones appear much earlier in life,³ and it is in this group of patients that well-performed surgery could reduce our mortality and complications rates. Table II reveals that our elective cases had an average age of 50 years with only 18 per cent of the patients being over 65 years of age. In contrast, our acute cases had an average age of 60 years with 44 per cent being 65 years of age or older. As will be noted later, this latter group was responsible for the majority of the surgical complications. The common duct was explored in 24 of the 157 chronic cases, or in 15 per cent. Stones were found in the common duct in 16 of the 24 explorations.

Acute Cholecystitis

Acute cholecystitis is in reality a very broad term. It embraces a number of anatomic lesions from the mildest edema and congestion to advanced gangrene and perforation. Thoughts concerning the etiology of acute cholecystitis have changed throughout the years. For many years infection or bacterial invasion was believed to be the primary etiological agent. Now there is almost universal agreement that acute cholecystitis is due to obstruction of the outlet

TABLE I
COMPLICATIONS OF GALLSTONES

- | |
|---------------------------------------|
| 1. Chronic cholecystitis |
| 2. Acute cholecystitis |
| a. Gangrene of gallbladder |
| b. Perforation of gallbladder |
| 3. Hydrops and Empyema of gallbladder |
| 4. Common duct stone |
| 5. Pancreatitis |
| 6. Cholangitis and liver abscess |
| 7. Biliary cirrhosis |
| 8. Carcinoma |
| 9. Biliary fistula |

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COMPLICATIONS OF GALLSTONES / Brown

of the gallbladder and to the irritating action of some of the constituents of bile on the gallbladder wall. Almost all series report a very high incidence of gallstones^{4,5,6} and stones were found in 85 per cent of our cases of acute cholecystitis. In the early stages of acute cholecystitis the change in the gallbladder and around the cystic and common ducts is

TABLE II
AGE OF PATIENTS

Average Age	Elective 50 Years	Emergency 60 Years
Patients 65 years or older	28 of 157 (18%)	35 of 80 (44%)

that of edema. Then there is further distention of the gallbladder, and later there is impairment of lymphatic flow and vascular supply. This may result in gangrene, and perforation may follow. Secondary bacterial invasion frequently follows.

The treatment of acute cholecystitis is now generally regarded as surgical,⁷ the timing of the surgery varying with individual clinics. Many prefer immediate surgery, while others advocate delayed operative management.⁸ We have used both methods, since each patient must be individualized. The local process must be evaluated, but the general condition of the patient must be studied thoroughly. Many of the cases are elderly patients with pulmonary, cardiovascular, and renal complications, and many are quite ill from sepsis, dehydration, and electrolyte abnormalities. Most of these patients will benefit from a period of a few hours of observation and preparation with fluid and electrolyte replacement. The 80 cases of acute cholecystitis referred to in this report were treated by emergency operation. Of these 80 acute cases, 44 per cent were in patients 65 years of age or older. Death occurred in four cases, compared to no mortality in the chronic cases. These cases will be discussed later. In addition to these 80 cases we saw 19 cases of acute cholecystitis which we elected to treat by delayed operative management, making a total of 99 cases of acute cholecystitis encountered. The principal reason for our selection of the delayed treatment of these cases was the association of pancreatitis, which was seen in seven of these 19 patients. This complication is discussed further below.

Perforation of the Gallbladder

The end result of acute cholecystitis is often perforation of the gallbladder. Many authors have reported a low incidence of this complication. However, of our 80 cases of emergency surgery for acute cholecystitis, seven gallbladders were perforated. This represents 8.7 per cent of the acute cases and

is comparable to other series that report 11.2 per cent,⁹ 9.3 per cent,⁴ and 3.9 per cent.⁵ These statistics bear out the fact that acute perforation is by no means rare. The mortality in cases of perforation is high, averaging approximately 20 per cent,¹⁰ and in our series one death occurred in a case of perforated acute cholecystitis. This complication could be prevented by elective operation of chronic cholecystitis with stones.

Acute Cholecystitis Following Surgery for Unrelated Disease

An occasional case of acute cholecystitis occurs in a patient who has recently undergone surgery for an unrelated disease. Glenn¹¹ reported 18 such cases in 1956, and in 1958 he reported that he had had 40 cases.¹² It is thought that this type of acute cholecystitis is related to the period of fasting prior to surgery, during surgery, and for a few days following surgery. During this interval bile production is continuous, and the bile becomes more and more concentrated in the gallbladder. The concentrated viscid bile is irritating to the gallbladder, which now is overdistended. When the fast is broken and the patient resumes oral feedings, the flow of bile is stimulated. However, because of the inflammatory response of the mucosa, and especially if there is already a stone present, sudden obstruction occurs.

Three of our acute cases fell into this category. One case followed a hysterectomy done on the Gynecological Service; another case followed a transurethral resection of the prostate done by the Urological Service; and the other case followed a saphenous vein stripping done by our Service.

Acute Cholecystitis Following Previous Gastrectomy

Still another interesting fact came to light in our study. We have seen five cases of acute cholecystitis in patients who had previously had gastrectomies for duodenal ulcer. One of these cases had perforated gallbladder and is briefly reported below. These cases point out the interesting fact that many of our patients with the so-called "post-gastrectomy syndrome" may actually have biliary tract disease.

A 40-year-old white male was admitted to the hospital with the chief complaint of right abdominal pain. He had had a simple closure of a perforated ulcer ten years previously and then a subtotal gastrectomy three years prior to the present admission. The present illness began two days prior to admission with the onset of epigastric pain, nausea, and vomiting. The pain then became more localized in the right abdomen with some radiation to the flank and back. By the time of admission the pain was further localized in the right upper quadrant. The temperature was 102°F. pulse 110

and white blood count 25,000. There was marked muscle spasm in the right upper quadrant, and peristalsis was absent. The patient was operated upon and had acute cholecystitis with cholelithiasis, with perforation and extensive necrosis of the retroperitoneal tissues from pancreatitis. A cholecystectomy with common duct exploration was performed and he did well.

Common Duct Stones

Choledocholithiasis is one of the serious complications of gallstones. There may be varying degrees of obstruction to the common duct, and with obstruction there is cholangitis and liver damage in the form of abscess and biliary cirrhosis. Pancreatitis may be associated with this, especially when the stone is impacted at the ampulla of Vater. As can be seen from Table III, we explored the common

TABLE III
COMMON DUCT EXPLORATION

	Number of Cases	Duct Explored	Duct Stones Found
Elective cholecystectomy	157	24 (15%)	16
Acute cholecystitis	80	26 (33%)	14
Total	237	50 (21%)	30

duct in 21 per cent of our total cases, the frequency of choledochostomy being doubled in acute cholecystitis. This fact has been noted by other authors.¹³ Our indications for common duct exploration are those listed by others in the literature^{13,14}: namely, jaundice or a history of jaundice, palpation of a stone in the common duct, distention of the common duct, small stones in the gallbladder, stone in the cystic duct, distention of the cystic duct, and the association of pancreatitis.

Pancreatitis

Acute pancreatitis is seen quite frequently in association with acute cholecystitis. The incidence of this complication varies considerably in the literature.¹⁵ It is often seen in the presence of a common duct stone with obstruction at the ampulla of Vater, allowing for reflux of bile into the pancreatic duct. It has also been explained on the basis of temporary spasm of the Oddi's sphincter in the presence of acute cholecystitis. Patients with acute cholecystitis and associated pancreatitis are usually more seriously ill than those without pancreatitis. Two of our four deaths in the acute group occurred in patients who had pancreatitis in addition to the acute gallbladder process. Both of these patients had common duct stones.

In our 80 cases of acute cholecystitis treated by emergency surgery we found evidence of pancreatitis at surgery in eight patients, or in 10 per cent. In addition to these eight cases, we saw seven other

cases of acute cholecystitis with pancreatitis, as evidenced by elevated serum amylase determinations, which were elected to be treated by delayed cholecystectomy.

Pancreatitis is also a dreaded post-operative complication of biliary tract surgery, especially following choledochotomy.¹⁶ The mortality of this post-operative complication is extremely high. One of the deaths of our acute cases bears out these statements. This was a man with an acute gangrenous gallbladder, pancreatitis, and a common duct stone. Emergency cholecystectomy and choledocholithotomy were performed. The patient was quite ill, but he improved until he had a T-tube cholangiogram. He immediately had a flare-up of pancreatitis and died with extensive necrotizing pancreatitis. The occurrence of pancreatitis following T-tube cholangiography is a most interesting observation, and we have seen this in a milder form in two other cases.

Cholangitis and Liver Abscess

These are usually complications of choledocholithiasis and are very grave conditions. We had three cases showing cholangitis, and one of these had multiple liver abscesses. This is briefly reported:

A 65-year-old white male had a 30-year history compatible with biliary tract disease but was fairly well until three days prior to admission, when he had the sudden onset of severe epigastric pain. Nausea and vomiting followed, and the pain became more localized in the right upper quadrant. The pain and vomiting continued, and he became icteric. The patient was quite ill on admission and had a serum bilirubin of 6.5 mgm. per cent and an elevated serum amylase. He was treated conservatively in an attempt to prepare him for surgery. However, he became even more ill and was operated upon two days after admission. He had a gangrenous gallbladder, common duct stone at the ampulla of Vater, pancreatitis, extensive cholangitis, and multiple liver abscesses. A cholecystectomy and choledocholithotomy were done. Following this he did poorly and died a "liver death" on the ninth post-operative day. Autopsy revealed the multiple liver abscesses.

Carcinoma

Carcinoma of the gallbladder is another dreaded complication of cholecytic disease. The prognosis is poor, only a very few patients surviving five years. It has been stated that one per cent of the patients subjected to biliary tract surgery will be found to have carcinoma of the gallbladder.^{17,18} Glenn¹⁹ states that in patients 65 years of age or over subjected to biliary surgery approximately 10 per cent will have carcinoma of the gallbladder or biliary

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ducts. Gallstones are associated with carcinoma of the gallbladder in the majority of cases, the incidence varying from 55 per cent¹⁸ to 73 per cent.¹⁷ The symptoms presented by the patients are usually those of chronic gallbladder disease and cholelithiasis, and frequently the carcinoma is found unexpectedly at surgery. The patients usually have had the symptoms for many years. Radical surgery, including hepatic lobectomy, is now being performed for this disease, but it seems that early cholecystectomy for gallstones offers our best avenue of approach for a higher survival rate.

We have had four cases of carcinoma in our series of cholecystectomies, two being primary carcinoma of the gallbladder and two of the biliary ducts. All four cases had gallstones. In two cases portions of the liver were resected with the gallbladder, and in one case a segment of duodenum was also removed. The longest survival we had was three years.

Internal Biliary Fistula

Spontaneous internal biliary fistulas may be found between any portion of the extra-hepatic biliary system and any adjacent portion of the gastrointestinal tract.²⁰ The most frequent site is between the gallbladder and the duodenum. The principal cause of the fistula is usually gallbladder disease with stones or a penetrating peptic ulcer,²¹ with carcinoma being a rare cause. The fistula usually has its origin as acute obstructive cholecystitis.²⁰ A stone is usually lodged in the ampulla of the gallbladder or in the cystic duct and progressively produces the changes seen in acute cholecystitis, including areas of gangrene. The serosa of an adjacent organ becomes irritated and adheres to the gallbladder. Further gangrenous changes occur, and there is some thrombosis of the vessels of the adjacent viscera. Necrosis occurs, and the fistula is formed. In our series of cases are found three patients with a cholecystoduodenal fistula.

Gallstone Ileus

After the formation of an internal biliary fistula a large gallstone may pass into the gastrointestinal tract. Intestinal obstruction due to a gallstone is not a rare finding. More rarely, the stone may enter the gastrointestinal tract via the ampulla of Vater.^{22,23} We have had one case of small bowel obstruction due to a very large gallstone.

External Biliary Fistula

An external biliary fistula may begin when the acute gallbladder becomes adhered to the parietal peritoneum. We had one such case in a 61-year-old man who had no previous biliary tract history, but

who developed a small subcutaneous abscess of the abdominal wall in the right upper quadrant, which he opened himself and collected large quantities of gallstones intermittently for one year before presenting himself. The fistulous tract was packed with gallstones, as was the gallbladder which was plastered to the abdominal wall and had a tremendous stone impacted in its ampulla.

Complications of Surgery

It is interesting to compare the complications of elective gallbladder surgery to those of emergency and complicated biliary tract surgery. Even under the most optimum of conditions and in treating the early, uncomplicated cases of gallbladder disease, the percentage of complications indicates that this type of surgery is not to be undertaken lightly. Table IV compares the two types of cases in our

TABLE IV
COMPLICATIONS OF SURGERY

	Number of Cases	Number of Complications	Number of Deaths
Elective cases	157	19 (12%)	0
Emergency cases	80	28 (35%)	4 (5%)
Total	237	47 (19%)	4 (1.7%)

series. The 12 per cent complications of our elective series is reduced to 8.9 per cent, if we eliminate the choledochostomies and consider our "elective series" as purely uncomplicated cases. This will increase the rate of complications in the complicated cases even more. Others have reported complication rates in chronic cholecystitis of 9.8 per cent for cholecystectomy with choledochostomy, and 8.9 per cent for cholecystectomy alone;²⁴ of 14 per cent in all elective cases;²⁵ and Strohl and Diffenbaugh¹ reported 17.3 per cent complication rate in the elderly patient. This is borne out in our series.

In our cases of acute cholecystitis, complications occurred in 35 per cent of the patients. It is interesting to note that almost half of the patients in this group were over 65 years of age. Others report complication rates in acute cholecystitis of 9.6 per cent for cholecystectomy alone, 12.8 per cent for cholecystectomy and choledochostomy⁷ and varying percentages up to 37 per cent.²⁵ The majority of our complications were pulmonary and cardiovascular, which is to be expected in any series dealing with elderly patients.

Mortality

There was no mortality in our elective cases, but we had five per cent mortality in the acute cases, giving an overall mortality of 1.7 per cent. This compares favorably with other series of cases from large institutions.^{7,6,25} As noted in Table V, three of our four deaths in the acute cases occurred in patients 65 years of age or older. The high incidence

TABLE V
CAUSES OF DEATH

Cause of Death	Age	Pathology at Surgery
1. Pancreatitis	50	Gangrenous cholecystitis Common duct stone Pancreatitis
2. Multiple liver abscesses	65	Acute cholecystitis Multiple liver abscesses Cholangitis Common duct stone Pancreatitis
3. Atelectasis and pulmonary edema	82	Gangrenous cholecystitis Perforation of gallbladder
4. Thyroid crisis and lower nephron nephrosis	71	Acute cholecystitis Common duct stone

in older patients has been described repeatedly before.^{1,3,6}

One of our deaths was due to acute necrotizing pancreatitis. This case was briefly described in the section on pancreatitis. Another death was due to liver abscesses and this was reported in the section on liver abscess. Another death occurred in an 82-year-old lady with a perforated gallbladder. She was in very poor condition on admission and died post-operatively with extensive atelectasis and intractible pulmonary edema.

A 71-year-old lady with a common duct stone and acute cholecystitis died post-operatively in a thyroid crisis. She had had a tremendous multi-nodular adenomatous goiter for years and was thought to be non-toxic. She rapidly became toxic and could not be controlled by any various heroic means. Bartels²⁶ has reported the very interesting problem of hyperthyroidism in patients over the age of 60 and states that 75 per cent of the patients with adenomatous goiter in the seventh decade will have hyperthyroidism. Hyperthyroidism in nodular goiter increases each decade, and its development may be very insidious.

Discussion

The complications of gallstones are severe. The majority of complications occur after long-standing biliary tract disease and usually is seen in the elderly patient. Of our 237 cases, 80 had acute cholecystitis at the time of surgery, seven had perforations of the gallbladder, 50 had common duct exploration in which 30 had stones found in the common duct, eight had pancreatitis (two had empyema of the gallbladder, three had cholecysto-duodenal fistulas, one had a cholecysto-epidermal fistula, one had multiple liver abscesses, three had cholangitis, and four had carcinoma).

The surgical mortality and morbidity are much higher in patients having these complications. The five per cent mortality in the emergency cholecystectomies and the zero mortality in the elective cases reveal the importance of early cholecystectomy for

gallstones prior to the development of complicated biliary tract disease. Three of our four deaths occurred in patients over 65 years of age. These elderly patients have a high incidence of pulmonary, cardiovascular, renal, and systemic diseases which increase the risk of surgery tremendously. Non-fatal complications of surgery were three times more frequent in the cases with serious complications of gallstones. Choledochostomy was twice as frequent in the acute cases. Almost 50 per cent of our acute cases were in patients 65 years of age or older. The interpretation of these facts indicate that early cholecystectomy should be considered seriously in every case of cholelithiasis.

Summary and Conclusions

1. A series of 237 consecutive cholecystectomies is presented with a brief resume of the complications of gallstones.

2. Patients with serious complications of gallstones had a five per cent mortality compared to a zero mortality in uncomplicated cases. Post-operative complications were three times more frequent in the cases of biliary tract complications.

3. Forty-four per cent of the emergency procedures were in patients 65 years of age or older, and 75 per cent of the deaths were in this group.

4. Surgery should be carried out prior to the development of the biliary tract complications.

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AWARD OF THE DISTINCTIVE SERVICE MEDAL



Left, Gov. Ernest Vandiver and right, John T. Mauldin, M.D., Atlanta.

DEPARTMENT OF DEFENSE
MILITARY DIVISION
STATE OF GEORGIA

GENERAL ORDERS
NUMBER 31

25 June 1959

AWARD OF THE DISTINCTIVE SERVICE MEDAL

Under the provisions of Section 89 (b), Military Forces Reorganization Act, Georgia Laws, 1955, for exceptionally meritorious and distinctive service from 1 January 1958 through 31 December 1958, the Distinctive Service Medal is awarded:

COLONEL JOHN T. MAULDIN, AO-312717
116th Tactical Hospital

Colonel John T. Mauldin, AO-312717, 116th Tactical Hospital, Georgia Air National Guard, distinguished himself by meritorious and selfless service in connection with operations pertaining to organizations and functioning of 116th Tactical Hospital. Colonel Mauldin's natural leadership abilities and personal interest have been largely responsible for molding the 116th Tactical Hospital into an excellent unit.

During this period, Colonel Mauldin was instrumental in finalizing a training program for the 116th Tactical Hospital in which the complete operation of the USAF Dispensary at Dobbins Air Force Base is taken over on training weekends by the Air National Guard. In this operation, personnel of the 116th Tactical Hospital, in addition to conducting routine physical examinations, administer to medical needs of the Regular Air Force, Air Force Reserve, and United States Navy. This project was undertaken with full cooperation of USAF medical personnel and has contributed very much to the training program of all personnel assigned to medical and medical administrative duties. Under Colonel Mauldin, the morale, esprit de corps, capability, and performance of the 116th Tactical Hospital are of great value to the Georgia Air National Guard. Through his high standard of conduct, leadership, and devotion to duty, Colonel Mauldin has brought great credit upon himself, the 116th Fighter Interceptor Wing, and the Air National Guard of Georgia.

BY ORDER OF THE GOVERNOR:

OFFICIAL:

George J. Hearn
GEORGE J. HEARN
Major General, Ga ARNG
The Adjutant General

GEORGE J. HEARN
Major General, Ga ARNG
The Adjutant General

CLOSED TREATMENT OF HERNIATED INTERVERTEBRAL LUMBAR DISCS

No improvement may be anticipated with this method, if the disc is completely ruptured out free in the spinal canal or if it is an old settled disc.

DARIUS FLINCHUM, M.D., *Atlanta*

THE PAINFUL BACK is a complex ailment. One must approach the problem with caution and humility. Many pitfalls await us in the diagnosis and the treatment.

A bulging or ruptured intervertebral disc is one positive cause we know of back and leg pain. This was not scientifically proved to be the cause of a syndrome of pain until this past year, when Smith and Wright¹ left a loop of nylon behind after removal of a herniated disc and relief of pain was obtained. They could, by pulling on the nylon thread, touch the nerve root at the exact spot the disc gave pressure and reproduce the same previous pain syndrome from which the patient was suffering.

Previously, in 1948, Falconer, McGeorge, and Begg² injected the nerve root with procaine and then by straight leg raising could have the nerve under pressure against the bulging disc without pain.

It is speculation to estimate the frequency of disc pathology in the overall cause of back pain. Degeneration, in the way of a decrease in fluid content of the disc with associated joint changes, occurs in all of us on reaching adulthood and beyond. As we grow older, more degeneration is expected, and most of us can expect some transient backaches, probably as a result of increasing age.

Disc Function

The disc does serve an important function and makes an important viable unit of the spine. It consists of the hyaline cartilage plate of the vertebral body, the soft central portion (nucleus pulposus), which is surrounded by the supporting thick fibrous structure, annulus fibrosus. The posterior annulus is thinner and allows protrusion of the disc usually posterolaterally. The central portion is a

hydrodynamic ball, and the axis of motion is in flexion since it is situated more posteriorly. The whole disc serves as a cushion allowing free motion of the spine in all directions. Discs are rugged structures that can withstand stress. When they are weak from congenital insufficiency or degeneration, a disc may bulge or rupture under strain or without injury.

If the whole disc is lost, the vertebral bodies may come together, and after many years we find the articular cartilage of the facets disintegrates with sclerosis of the adjoining vertebrae. Six months or more after disc degeneration, we are apt to see some marginal reaction of the vertebral bodies in the way of osteophytes. There is tremendous variance in individuals as to "when" and "why" they have symptoms in their backs as a result of disc difficulty. We see people all the time with one or many narrow intervertebral spaces and large osteophytes, and yet, they are symptom free. We know, too, that we can have, as demonstrated by McRae³, actual herniated intervertebral discs and never have symptoms. At autopsy a large bulging disc can be found even though the individual never had a history of back or leg pain.

Specific Treatment for Herniated Intervertebral Disc

We often wonder what happened to the many people who no doubt had disc trouble before this specific cause of back and leg pain was established by Mixter and Barr⁴ in 1934. There really are very few older people walking around today from crippling effects of the disc prior to our knowledge of this clinical entity. I know they have not died from this trouble. The effect of the disc then must tend to subside. Edema of the nerve root will subside. The size of the protruding disc is not fixed and actually may absorb some in time, as demonstrated by

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LUMBAR DISCS / Flinchum

Lindblom⁵. The bulging may recede between the vertebral bodies. A nerve root may move off the underlying herniated mass.

I remember one man in particular during my grade school days, who lived on the adjoining farm and whom I used to visit on my walk to and from school. This neighbor rather suddenly developed severe back pain with "lightening pain" (as he described it) extending down to his right foot. Severe pain and disability continued for several weeks. After about three months in bed with legs propped up on pillows, the pain subsided and his trouble was over. I see this man when I go home to Virginia. It has been over 30 years since this episode, and he is having no trouble with his back or leg. Furthermore, there has been none since the long period of bed rest. In my mind, I feel that he had a ruptured disc, that was overcome by rest. Most people in this time of economic duress cannot take time for recovery. We must get on with our problem.

First, the diagnosis must be established by history and physical examination. Discomfort is noted to be worse when up. Back movement is limited with a list, percussion and point tenderness is noted over the area of disc involvement. Sciatic stretch tension test, performed as described by Deyerle,⁶ is noted to be positive on the involved side. This is quite specific for nerve root pressure and perhaps the most valuable physical sign. There may be noted reflex changes in the way of decreased Achilles reflex. Some muscle weakness or atrophy may be present. Increase or diminution of sensation in the affected dermatome may be noted, but it is at times a variable finding. Myelogram and/or discogram may be done, but we should always remember to treat the patient and not the X-ray.

It is generally agreed that the initial treatment should be conservative. It must be remembered, too, that in chronic cases recurrences tend to become milder and less frequent.

Conservative methods of treatment for herniated intervertebral disc consist of: (1) flexion rest; (2) symptomatic-analgesics-muscle relaxants; (3) traction; (4) manipulation under general anesthesia; (5) plaster flexion corset for six weeks; and (6) flexion exercise and stress.

Of these, rest is probably the most important. Traction of the legs in contour flexion position, straight leg traction or 90-90 traction with the hips flexed 90 degrees and the knees flexed 90 degrees with traction on the thighs probably helps by keeping the patient down and perhaps giving a little spread of the intervertebral spaces. My choice is flexion rest in bed in a modified Fowler's position



Figure 1: The involved side is manipulated first while traction is applied to the opposite leg.

along with something for relief of pain. Muscle relaxants have been disappointing. The intravenous form of Robaxin®* (methocarbamol) appears to hold great promise, however, for relaxation of muscle spasm and muscle pain associated with disc and other musculoskeletal complaints.

After a few days of flexion rest, if no appreciable improvement is noted, it is my choice to try manipulation of the spine under general anesthesia. An anesthetic is necessary because of severe restriction of motion these patients have and pain on any attempted movement of the back.

The involved side is manipulated first. While traction is applied on the opposite leg, the flexed knee is brought toward the opposite shoulder with one hand also under the involved side of the sacrum in order to get some widening of the posterolateral intervertebral spaces (Figure 1). The same procedure is then done on the other side (Figure 2), after which the lumbar spine is brought up in flexion (Figure 3).

Some advantages of manipulation are immediate



Figure 2: The uninvolved side is also manipulated.

*Courtesy of A. H. Robins Company, Inc.



Figure 3: The lumbar spine is brought up to acute flexion while the patient is under anesthesia.

relief of pain, short hospital stay, and reactive fibrosis of the nerve root may be prevented. No help can be expected from manipulation if the disc is completely ruptured out free in the spinal canal or if it is an old settled disc.

Some of the contraindications to manipulation are: spine anomaly, suspicion of cord tumor, bilateral sciatica, extensive paresis or muscle atrophy, older age—over 50, hypertrophic arthritis, and osteoporosis. Theoretically, one might state that by flexion the disc could be further extruded and produce paralysis. Such has not been my experience in over 180 cases. Mensor⁷ in reporting manipulation for 205 cases of herniated disc and no complications. He reported satisfactory or complete relief of pain in 64 per cent of private cases and 45 per cent of industrial cases. I have never noticed any nerve root loss or any increase in symptoms following manipulation. The vast majority, around 75 per cent, are completely relieved of discomfort on awaking. In some no relief has been obtained, and in these at operation usually a completely extruded disc was found. The symptoms, however, were not made worse by manipulation but remained unchanged. Some have had recurrence necessitating more treatment. Manipulation is usually restricted to one time, occasionally two.

Previous writings on manipulation emphasized extension of the spine, and this probably is wrong since we do note that sometimes at operation we can make a disc bulge on extension. The spinal canal and foramen are made narrow by extension. Once at operation, when we were removing the disc, we flexed the table more and raised the kidney rest, and the bulging disc was noted to disappear. It is believed by manipulation in flexion that either the bulging mass can be lessened or perhaps shifted back into the interspace or else the nerve root can be moved off the bulging herniation. In either event symptoms are relieved in many instances.



Figure 4: A flexion plaster corset with adjustable straps should be worn for six weeks following manipulation or other means of conservative treatment.

A light flexion plaster corset is applied before the patient is allowed to be up (Figure 4), and this is worn for a period of six weeks. This is most important as we have let some go without cast support or with just a corset, and we did not get as good results as when they were kept in plaster. The plaster is made removable by attaching three straps and can be tightened with these straps in order to make it more comfortable. It is also best to apply this form of support to the back after a period of flexion rest if the patient responds to that or a period of traction as the patient will also get better relief by conservative treatment by this period of immobilization to the back. Plaster is best too in that the patient gets the idea that he is not in a permanent support.

After a period of six weeks the patient is given flexion exercises in order that he may keep his back out of the lordotic position. It is also good to get back to putting some stress on the back according to tolerance. It is not good for these people to give up. A moderate amount of exercise and stress certainly is in order.

If conservative treatment fails and there persists severe intractable pain and disability or frequent recurrence of pain severe enough to interfere with the patient's work, surgery is indicated. Up to 10 per cent of disc patients may require surgery.

After conservative treatment many have no more trouble. There are some who after surgery have no appreciable trouble. Others will note settling and painful degenerative arthritis of the involved vertebrae five years after simple disc removal. There are a few disc patients who after excision and spine fusion continue to hurt. Even after cordotomy some will still complain of discomfort some place. There are a few who are not relieved or even helped by any means of treatment.

340 Boulevard, N.E.

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LUMBAR DISCS / Flinchum

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DR. IRVILLE MacKINNON NEW YORK PSYCHIATRIST TO HEAD STATE HOSPITAL

DR. IRVILLE HERBERT MacKINNON, professor of psychiatry at Columbia University, College of Physicians and Surgeons, New York, has been selected as superintendent of Milledgeville State Hospital, it was announced by Dr. Thomas F. Sellers, director, Georgia Department of Public Health. He will report for duty at the hospital about mid September at a salary of \$23,880 plus family maintenance.

"We are very happy to obtain the services of such an outstanding man to administer the hospital and develop the psychiatric, medical, and supportive programs there. He will have full authority and responsibility for the operation of the hospital and will work closely with the State Health Department in planning for total statewide mental health services," Dr. Sellers said.

Dr. John H. Venable, director of the Milledgeville State Hospital, said, "Dr. MacKinnon is just the type of man the health department has been hoping to get ever since the hospital was put under our administration. We believe this is the beginning of a most effective

service program for the hospital and the mentally ill in our state."

Dr. MacKinnon has been associated with Columbia University continuously since 1949 and has been professor of psychiatry since 1954. He is also attending psychiatrist at New York Presbyterian Hospital. He is administrator of the New York Psychiatric Institute and heads the training program of Columbia University, College of Physicians and Surgeons and the New York Psychiatric Institute which is associated with the New York State Training Program for psychiatrists. Dr. MacKinnon also serves as a member of the Lunacy Commission of the Governor of New York.

Born in Boston, Massachusetts in 1898, Dr. MacKinnon received his M.D. degree from Tufts Medical School in that city. He had further training at hospitals in South Dakota and Maine. He is a diplomate of the American Board of Psychiatry and Neurology and member of the American Medical Association and the American Psychiatric Association.

SOUTHEASTERN SURGICAL CONGRESS 1959 PRIZE SCIENTIFIC PAPER AWARD

The Southeastern Surgical Congress announces its Annual Prize Scientific Paper Award for 1959. The best unpublished contribution on surgery or allied subjects will be awarded \$100.00 and expenses for the winner to attend its next annual meeting in New Orleans. The second place winner will receive \$50.00 and third place winner will receive \$25.00.

The contest is open to residents in AMA approved residences in the States of Alabama, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.

Three copies of the paper should be sent to the Councilor of the state in which the resident is living before December 1, 1959. The Councilor's name may

be obtained by writing to the office of the Southeastern Surgical Congress at 1032 Hurt Building, Atlanta 3, Georgia. The winner will present his paper before the Southeastern Surgical Congress Assembly in New Orleans, Louisiana, at the Roosevelt Hotel, March 21-24, 1960. The winner's expenses will be borne by the Congress, and the prize of \$100.00 cash will be awarded at this meeting.

The Southeastern Surgical Congress reserves the right to submit the paper to the Editorial Board of its official publication, *The American Surgeon*, for publication. If the Editorial Board rejects the paper, the author is then free to seek publication elsewhere. All manuscripts must be typewritten in English in a form suitable for submission for publication.

CYSTIC FIBROSIS IN ADOLESCENCE

Report of a case with unusual associated findings and extraordinary response to treatment with pancreatic extract.

BENJAMIN B. OKEL, M.D., *Atlanta*

DUE TO INCREASED clinical awareness and recent popularization of the sweat test,⁴ the diagnosis of fibrocystic disease of the pancreas in the non-pediatric age group is becoming increasingly more frequent. Recent reports have recorded patients surviving to their late teens^{2,3,4,5,6,7} and even to their twenties^{8,9}. Usually such longevity is related to minimal or absent pulmonary involvement. The role of prophylactic antibiotics and pancreatic extract may also be important in extending life but has yet to be satisfactorily evaluated.

As has been pointed out by di Sant'Agnese¹⁰, mucoviscidosis is a disease by no means limited to the pancreas and lungs, but rather affects many and perhaps all exocrine glands. The following case illustrates this multiple system involvement and brings up the possibility of the eye and genitourinary system being involved in mucoviscidosis.

Case Report

E.E.L., a Caucasian male was first seen at Grady Memorial Hospital at the age of 12 years, when he was examined in the Ophthalmology Out-patient Department for defective vision. Examination of the left eye then revealed a lenticular coloboma manifested by a notchlike defect in the lateral superior quadrant of the lens periphery. There was considerable distortion across the entire lens and a resulting uncorrectable astigmatism. There was also a feather-shaped postero-centrally located cataract in the same lens.

The patient was first admitted to Grady Memorial Hospital on November 1, 1957, at the age of 13 with cough, sore throat, fever, and X-ray findings of retrocardiac pneumonia. His weight at the time was 37 pounds, which is less than the three percentile level. Mucoviscidosis was considered as a cause of his underdevelopment but not definitely

established. His respiratory symptoms responded well to a course of antibiotics, and he was discharged on no specific treatment.

Approximately one year later on November 6, 1958, the patient, now 14 years old, was admitted to the Urology Service of Grady Memorial Hospital for evaluation of an episode of gross hematuria some three days earlier. Presenting symptoms other than hematuria were left costovertebral angle pain and mild suprapubic tenderness. He had had slowly progressive anorexia and weakness since the previous admission and weight now was only 39 pounds. Urological examination revealed a non-specific urethritis and trigonitis as manifested by microscopic hematuria on the two-glass test and by hyperemia and splotchy areas of severe inflammatory reaction in the posterior urethra and trigone area of the bladder on cystoscopy. Serum calcium was 6.5 mg. per cent initially and 7.7 mg. per cent when repeated five days later. Symptoms abated spontaneously on bed rest alone, and he was transferred to the Medical Service for evaluation of his unusual blood calcium levels and his history of failure to grow.

Inquiry into past history revealed a bout of pneumonia in infancy and a subsequent mild cough with repeated upper respiratory infections. The patient's birth and early infancy were considered normal by the mother. His stools had never been considered abnormal in quantity or quality. Since infancy he had had periodic "sinking spells" manifested by transient squatting and stridulous breathing.

Family history was significant in that a double first cousin, the offspring of marriage between a paternal uncle and a maternal aunt, was likewise underdeveloped, being approximately the same age and weight.

Physical examination revealed only a markedly emaciated white male with the previously mentioned eye findings. He appeared approximately one-half his chronological age. Examination of the heart,

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CYSTIC FIBROSIS / Okel

lungs, and abdomen was unrevealing.

A chest X-ray revealed mild diffuse pulmonary emphysema with streaking in the left lower lobe.

A 50 gram glucose tolerance test was abnormal, revealing blood sugars of 73 mg. per cent fasting, 234 mg. per cent at one hour, and 174 mg. per cent at two hours.

Repeated blood electrolytes were not remarkable, the calcium now being 9.2 mg. per cent. Urinary Sulkowitch exam was 1+. Repeated urinalyses were not abnormal. An electrocardiogram was normal.

Duodenal aspiration revealed pancreatic secretions having amylase activity of 1366.2 Russell units and trypsin activity of 250 viscosimetric units per cc.—both normal values. Stools were formed, though slightly greasy in gross appearance and microscopically showed free neutral fat on staining.

I-131 labeled trioleate excretion in the stool was definitely abnormal being 42 per cent in 48 hours. (Normal less than two per cent.) Similarly tagged oleic acid excretion was 7.2 per cent. (Normal less than three per cent.)

Sweat electrolytes were elevated with sodium of 151 and chloride of 132 mEq/L. (Normal values are 59 and 32 mEq/L. respectively.)

The patient was discharged taking multivitamin tablets and Pancreatin Enseals® (Lilly) 1.5 grams thrice daily with meals. No special diet was emphasized, and essentially the same food was available as before hospitalization. He has since shown a spectacular gain of 18 pounds in ten weeks, now weighing 56¼ pounds, a 48 per cent increase in his discharge weight. Appetite, activity, and general well-being have likewise improved.

Repeated urinalyses have been negative.

A repeated 50 gram tolerance test showed values of 69 mg. per cent while fasting, 132 mg. per cent at 30 minutes, 206 mg. per cent at one hour, 162 mg. per cent at two hours, and 88 mg. per cent at three hours. Glycosuria has never been noted.

Repeated duodenal drainage showed a suboptimal (approximately one-third normal) pancreatic response to parenteral secretin. Two cc. of duodenal juice containing 2.6 mEq/L. of bicarbonate (as CO₂) was collected 20 minutes before intravenous secretin and 3.5 cc. containing 35 mEq/L. bicarbonate was collected 20 minutes afterward.

Radioactive-tagged fat excretion repeated while on therapy with pancreatin revealed 1.5 per cent fecal output in 48 hours.

Discussion

The clinical picture in this case was typical in having malnutrition, pulmonary involvement, decreased fat absorption, and abnormal sweat electro-

lytes. Even the familiar aspect of the disease was demonstrated by its probable occurrence in a cousin.

The suboptimal though definite pancreatic response to intravenous secretin and the normal concentrations of amylase and trypsin in the duodenal contents were not too surprising. This presence of normal concentrations of pancreatic enzymes in duodenal fluid by no means negates the diagnosis. Di Sant-Agnese¹⁰ and Richmond and Schwachman¹¹ have reported series of cases with fibrocystic disease having minimal or no discernible enzyme deficit. In view of a definite abnormality in fat absorption by isotope techniques and a spectacular therapeutic response to pancreatic extract, it is reasonable to assume that enzyme assay of duodenal fluid does not satisfactorily detect pancreatic insufficiency.

The initially low serum calcium levels noted in this case might well reflect pancreatogenic malabsorption of calcium. Such has been noted in other types of malabsorption. Whether the past history of syncope-like episodes represents hypocalcemic tetany is a moot point.

The presence of a diabetic glucose tolerance curve is an unusual and perhaps merely fortuitous occurrence in mucoviscidosis. Di Sant'Agnese reports one such case in a series of 397. He comments on the surprising rarity of diabetes in a condition that can so diffusely involve the pancreas.

A lenticular coloboma is a rare ophthalmic abnormality which is generally attributed to a developmental defect in the suspensory system of zonular ligaments. As in this case there is usually an associated post-nuclear cataract. Bonaccolto¹² recently reported a congenital coloboma of the lens associated with, and apparently due to, an area of cystic degeneration in the ciliary body. Since the ciliary body can be considered an exocrine gland, the possibility of the presently described coloboma being another manifestation of mucoviscidosis arises.

The fact that this case presented as hematuria brings up another interesting possibility. Anderson¹³ in a series of 49 autopsied cases of fibrocystic disease of the pancreas reported stricture of ureters with mild hydronephrosis in two cases, nephrolithiasis in one, chronic interstitial nephritis in two, and keratinizing metaplasia of the renal pelvis, ureter, or periurethral glands in six others. From these findings we might assume that abnormalities involving the kidneys, genitourinary mucosa and associated glands are also related in some way to this generalized exocrinopathy. Explanation of the patient's high renal threshold for sugar warrants further study.

The patient's rapid weight gain on pancreatic extract was indeed gratifying. Unfortunately, the

Appreciation is expressed to Dr. Rhodes Haverty and Dr. John T. Galambos for their assistance in preparing this paper.

usual case of fibrocystic disease does not show this phenomenal therapeutic response.

Summary

- 1. A case of cystic fibrosis, first diagnosed in adolescence, presenting with hematuria is reported.
- 2. The case is also notable for its associated findings, including coloboma of the left lens, transient hypocalcemia, and abnormal glucose tolerance curves.
- 3. Rapid weight gain occurred following the administration of pancreatic extract.

69 Butler Street, S.E.

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NURSING HOME HANDBOOK PUBLISHED BY GEORGIANS

THE NATION'S FIRST comprehensive book dealing exclusively with establishment, organization, and management of nursing homes and homes for the aged has been written by a group of Georgia authors.

The book is of particular significance to Georgia, which has a tremendous need for nursing homes and homes for the aged.

The authors, headed by Dr. R. C. Williams, are all present or recent staff members of the Division of Hospital Services, Georgia Department of Public Health. Dr. Williams is director of the Division.

Publisher of the 224-page book, "Nursing Home Management," is F. W. Dodge Corporation, New York. Co-authors are Margaret Bull Armstrong, director of nursing Services, Thomas Memorial Hospital, South Charleston, West Virginia; James F. Gunter, assistant administrator, Kennestone Hospital, Marietta; Edith McCulloch, former director of nurses, Kennestone; and Jack Stiller, chief of licensure, Division of Hospital Services.

"This book," said Dr. Williams, "endeavors to present information from many sources as a guide for those concerned with the operation of institutions providing care for the disabled and aged. While some of the persons now operating nursing homes or homes for the aged are registered nurses or licensed practical nurses, by far the majority of operators have had no particular training. For that reason some elementary material has been included in this book. It is intended to serve as a reference source for persons of varying backgrounds who seek information in this general field.

Special topics in this book include useful information relating to: structural arrangement; maintenance of physical plant; business and personnel management; care of patients, food service for the aged; safety programs; fire protection; community and public relations. Many other important phases of operating nursing homes and homes for the aged are discussed in simple, understandable terms.

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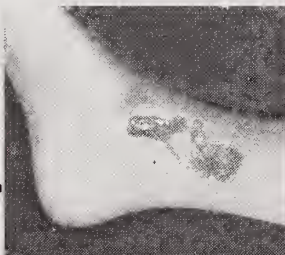
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CHRONIC LEAD POISONING

Staff of the Medical College of Georgia, *Augusta*

Dr. J. A. Kemp (Medicine): Medical Grand Rounds today will be concerned with a patient with chronic lead poisoning. Fortunately, this condition is rare in this area, but possibly for this reason, it may present a greater diagnostic problem to us than to physicians who encounter it more frequently. The patient will be presented by Dr. Avret.

Dr. E. T. Avret (Medicine): The patient is a 36-year-old Negro male who was admitted to Talmadge Hospital on August 29, 1958 with the chief complaint of pain in the abdomen, back, and legs. His illness began approximately three months prior to his admission. At that time he experienced a rather sudden blurring of vision, his eyes "began jumping back and forth," and immediately thereafter he had had a convulsive episode consisting of generalized clonic contractions with biting of the tongue but without sphincter incontinence. He remained unconscious for approximately 10 minutes. Upon regaining his faculties he was sent to a local hospital but no evidence of disease was found. Thereafter he complained of colicky, aching, generalized abdominal pain which radiated to his back in a girdle-like fashion and also into his thighs. The pain was followed by nausea and vomiting. He was hospitalized from May 28, 1958 until May 31, 1958, a clinical diagnosis of intestinal obstruction being made. He was referred to another hospital where he remained from May 31, 1958 until June 6, 1958. Laboratory data at this hospital revealed a cephalin flocculation of 2+ (48 hours), direct van den Bergh 0.63 mg. per 100 c.c. and indirect van den Bergh 25 mg. per 100 c.c., icterus index 8.5 units, thymol turbidity 1.1 units, and urine urobilinogen positive in 1:10 dilution. Infectious hepatitis was suspected.

Subsequently there were several episodes of blurred vision and nystagmus, but only three seizures, all of which were quite similar to the first. The

abdominal pain seemed to increase in frequency and intensity, beginning usually in the early morning and reaching a peak at evening. This pain was not related to food ingestion or bowel habits, nor was it accompanied by abdominal swelling, nausea, vomiting, or anorexia. No therapy given the patient seemed to be effective. It is interesting to note that the patient had worked in an aluminum plant for approximately one month prior to his illness. He also stated that several of his fellow employees had similar complaints.

He had had an appendectomy in 1937 with sequelae, typhoid fever in 1938, and pneumonia in 1939. Family history and review of systems were essentially non-contributory. One of the patient's habits that might be noteworthy is that he drinks homemade whiskey, admitting to having consumed three quarts during a nine-month period prior to his present illness.

Physical examination revealed a weight of 70 kilograms, temperature of 37.4°C., blood pressure of 200/120, pulse of 88 per minute (regular), respiration of 28 per minute. The patient was a well developed, well nourished, anxious Negro male who was complaining of abdominal and back pain. There was a definite lead line at the gum margins, and an 8 cm. scar in the left parietal region. The lungs were clear to percussion and auscultation. There was no evidence of cardiomegaly, arrhythmia, or valvular lesions. The abdomen, pelvis, and extremities were essentially normal. Neurological examination revealed no change in sensory modalities or motor function, nor was any ataxia or dysmetria demonstrable. The deep tendon reflexes were normoactive and no pathological reflexes were elicited. Impressions on admission were: (1) hypertension, probably essential; (2) possible heavy metal poisoning, especially lead; and (3) possibly porphyria.

Hemogram on admission revealed a hemoglobin of 9.5 grams per 100 c.c., hematocrit of 31 per cent,

Transcription of a regular weekly conference of the Department of Medicine, Medical College of Georgia, Augusta, Georgia, October 1, 1958.



Figure 1: Photograph of gum margin showing lead line.

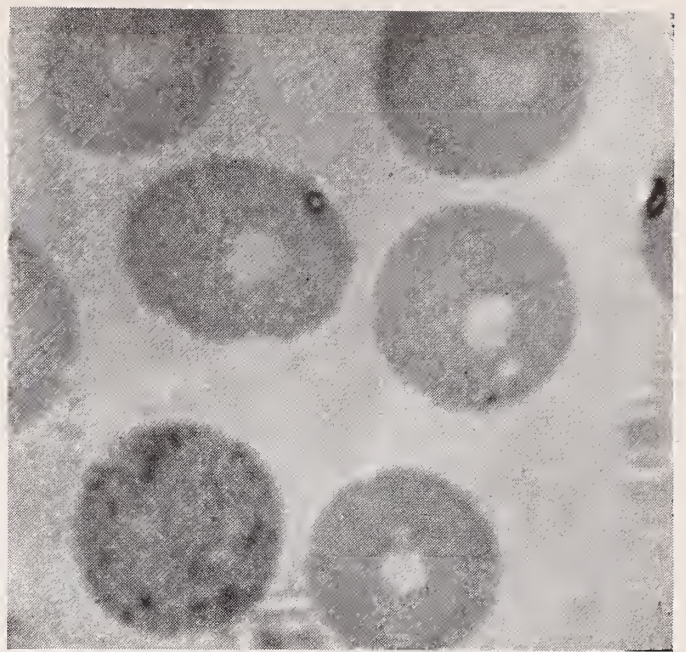


Figure 2: Photomicrograph of peripheral blood smear showing marked basophilic stippling.

white blood count of 10,200 per cubic mm. with a normal differential, and a corrected sedimentation rate of 27 mm. per hour. Basophilic stippling of the red cells was noted. The fasting blood sugar was 92 mg. per 100 c.c.; the BUN was 44 mgm. per 100 c.c., and the creatinine clearance was 70.2 c.c. per minute. The Addis count was normal. Urinalysis showed a trace of albumin. Serum electrolytes, total and fractional serum proteins, van den Bergh, thymol turbidity, cephalin flocculation, bromsulfalein excretion, protein bound iodine, serum cholesterol, L-E preparations, blood Kahn, and stool examinations for blood, ova and parasites—these tests were all normal or negative. The spinal fluid gave a positive Pandy test, but there were no cells. A urine lead determination was obtained on September 5, 1958, this being 80 micrograms per 24 hours. This represents the top range of normal at this laboratory, but a second sample obtained on September 11, 1958, contained 408 micrograms of lead for 24 hours. A urine test for coproporphyrin was strongly positive. The electrocardiogram revealed left ventricular hypertrophy. The electroencephalogram was normal. A chest roentgenogram was normal, upper G. I. series and barium enema examination were both negative. Skull roentgenograms demonstrated evidence of an old depressed fracture involving the left frontal parietal area. The intravenous pyelogram showed depression of renal function bilaterally.

During the early period of the patient's hospitalization, he continued to complain of abdominal pain and experienced hyperesthesias and hyperpathia of the thighs. These pains were resistant to codeine and salicylate therapy. The consultant in neurology thought that the patient probably had lead poisoning. As soon as the lead excretion of 408 micrograms per 24 hours was obtained, calcium disodium

versonate therapy was begun in a dosage of one gram per 15 kilograms body weight per day, repeated on three consecutive days. On the first day of treatment the lead excretion increased to 7,245 micrograms per 24 hours and the patient did not complain of any further pain. The course of calcium versonate therapy was repeated on two additional occasions with a week's rest between courses. The patient is presently completely asymptomatic and the lead line at gum margins has faded considerably.

Dr. Kemp: The patient is here with us. However, I believe the lead line and stippling of the red blood cells can best be demonstrated by the color slides that we have. These demonstrate the lead line of the gums (Figure 1) and the basophilic stippling of the erythrocytes (Figure 2). Does anyone wish to ask the patient a question? If not, we will let him return to the ward.

Lead poisoning may occur from exposure either to organic or inorganic lead compounds, but the organic compounds are more likely to cause an acute syndrome. Conversely the chronic syndrome is usually due to inorganic lead compounds. Chronic poisoning may occur from the ingestion of lead paints or lead sprays, from ingestion of lead toys by children, and from ingestion of water or whiskey that happens to have been exposed to lead pipes. Also it may occur from inhalation of fumes from burning lead, from burning storage batteries, and various soldering activities. There is some indication that the gastrointestinal route is more important than the respiratory route, and further there is some indication that perhaps rather meticulous care by exposed workers in cleaning the hands prior to eating may reduce the incidence of toxicity. The amount of lead that is required daily to produce symptoms of tox-

Medical Grand Rounds

icity is quite low, in the order of one mgm. per day. After lead is absorbed into the systemic circulation, it is laid down chiefly in the bones but also in the soft tissues, particularly the brain, the kidney, and the liver. Subsequently it is mobilized from the soft tissues and further deposited in the bone as tertiary lead phosphate. This deposition of lead follows very closely the metabolism of calcium. Those factors which cause deposition of calcium in bone cause lead also to be deposited in bone where it is non-toxic, while those factors which mobilize calcium from bone also mobilize lead and may cause acute toxicity in patients who have deposits of lead in their bone. This assumes particular importance in acidotic situations. The amount of lead that is excreted in the urine very closely parallels the amount of lead that is in the blood, and therefore this a good diagnostic test. The upper limit of normal in our laboratory is something like 80 micrograms per 24 hours.

The symptoms of lead poisoning are primarily gastrointestinal, neurological, and to a lesser extent, hematological. Dr. Kemble, I wonder if you will comment on the neurological manifestations seen in this patient.

Dr. John Kemble (Neurology): I was asked to see this patient because of convulsions which had some specific characteristics. I will comment on those in a moment. In children and adults the neurologic manifestations of lead poisoning are different. Usually in children there is increased intracranial pressure, perhaps manifested by coma, choked discs, and convulsions. Rarely in children are peripheral nerves involved, but this has been reported. In adults the onset may be quite varied and the manifestations variable. There may be convulsions, either generalized or focal, there may be various neurologic deficits representing cerebral involvement, such as hemiparesis, hemiplegia, hemianopia, and monoplegia. It is said that the radial nerves or the muscles innervated by the radial nerve are characteristically involved in adults. However, Russell Brain has commented on research that suggests that it is the muscles that are more commonly used that are involved, not characteristically the muscles innervated by the radial. There is experimental work with lead intoxication in animals that showed that other muscles could be involved by fatiguing them in the course of lead intoxication.

This patient describes very vividly a focal type of seizure, one that we commonly call an "adversive seizure." You remember the scar of the head is on the left, and this is where the radiologist reports a depressed skull fracture. The patient describes the

three seizures that he had as beginning with an involuntary turning of his eyes to the left. He says that he can't help it, that his eyes seem to jiggle, and turn forcibly to the left. Then his head starts to turn, keeps turning to the left and then, quoting him, "I don't know nothing after that." This happened three times. He says that the next thing he knows his friends are picking him up off the ground. The significance of all this is that the adversive seizure is usually a very good focal indicator of a discharging lesion in the opposite frontal area of the cortex. It frequently is, but that isn't the case in this man. The uniformity of the seizures makes one think that there is a discharging lesion in the right frontal area, but the EEG did not reveal such a focal abnormality. Now, what part does the depressed fracture play in the convulsive disorder in this man with proven lead intoxication? I can't tell yet, but my feeling is that clinically the best course is to handle the lead intoxication first, and then come to the management of whatever else we're dealing with that is involved in the seizure disorder. I think that the pattern of the seizure disorder points away from the fracture. I could find no neurologic deficit suggesting brain damage otherwise.

Dr. Kemp: This patient's symptoms seem primarily neurological, however, gastrointestinal symptoms can be severe. Dr. Moore, would you comment on this aspect of plumbism.

Dr. Victor Moore (Medicine): Before I begin on the gastrointestinal manifestations, there are a number of other non-industrial methods by which lead intoxication may occur, and since these are primarily gastrointestinal, I'll take the liberty of mentioning them. They are perhaps of more interest than practical value. You did mention the ingestion of paint, but it seems that this many times is found in children with picae, or appetite deviations, who for emotional or other reasons, are apt to eat flecks of dried paint. If this is lead-containing paint, the lead is absorbed, and intoxication may occur. Diagnostically it is stated that if a scout film of the abdomen is taken on admission to the hospital, little radio-opaque flecks may be seen scattered throughout the abdomen. It is important to do this before the intestinal tract is cleaned out, or else the tell-tale sign will be lost. It seems also that women in the Orient, particularly Japan, use face powder containing lead compounds. Japanese babies are apt to ingest some of this powder, either from nursing or from being carried on their mothers' backs, and getting it in their mouth, from the neck and shoulders of the mother. Lead colic in Japanese infants appears to be a fairly common finding. I do not believe you mentioned the fact that foreign bodies made of lead, such as might come from a gun, if retained in the

tissues for a long time, have also been incriminated as a source of lead absorption and intoxication.

The information I can find is somewhat fragmentary, but perhaps I can piece it together. As you mentioned, lead, when taken into the gastrointestinal tract, is absorbed and taken first to the liver; from there it is dispersed to other portions of the body. We wonder first if there are any hepatic lesions or damage that results from lead poisoning. If rats are fed food containing lead acetate, they are found to develop central necrosis and fatty metamorphosis in the liver, but it's extremely doubtful that this occurs in humans. I have not seen it described in the human liver. However, nuclear inclusion bodies are described in hepatic cells. These appear to be of more diagnostic than prognostic significance, and just as in this case, hepatic function is nearly always quite good. The gastrointestinal manifestations are primarily those of hypermotility of the intestine. Just what the basic physiological reason for this is seems to be somewhat obscure. Necheles claims that the hypertonicity of the intestine results from sclerotic changes in the splanchnic plexus and intrinsic nerve plexuses. Perhaps Dr. Kemble can elucidate on this. I have not been able to confirm it. One wonders also if this increased motor activity might not be the result of central impulses. We wonder, with the disturbance in porphyrin metabolism, if perhaps this might be somehow responsible, for certainly in porphyria we see a similar situation—abdominal cramps and constipation—perhaps on a similar mechanism. Dr. Sheppard tells me that most heavy metals are enzyme poisoners so perhaps there is some difficulty at the neuromuscular junction. Dr. Ahlquist may help us out there. At any rate, the result seems to be overactivity of the gastrointestinal tract, and I think all of the variety of symptoms that are produced can be related to this. The easiest is the diarrhea that occurs. Obviously when motor function of the gastrointestinal tract is accelerated, material is propelled along at a greater rate, and expelled at a greater rate, hence diarrhea. If activity becomes even more marked and dyskinetic, we have localized segments of spasm, resulting in pain and intestinal colic, which seems to be the outstanding and most characteristic gastrointestinal manifestation of the disease. Along with this localized spasm and colic we have interference rather than acceleration of progress of materials through the gut and so instead of diarrhea there is constipation. Not infrequently diarrhea and constipation may alternate, probably because of varying degrees of hypermotility and spasm. If the involvement is primarily of the upper gastrointestinal tract or the upper gastrointestinal tract as well as the lower, one may get some additional symptoms thrown in. Vomiting is frequent,

particularly in the acute forms of lead intoxication, though it is possible that this may be due to encephalopathy. Motor dysfunction and hypertonicity may result in indigestion, nausea, anorexia, and loss of appetite. Perhaps the foul breath that is described is due to motor disturbances and turbulence of material in the gastrointestinal tract with retrogression of enteric organisms up the gastrointestinal tract. All of these are fairly nonspecific manifestations and when found one can only say that there is gastrointestinal hypermotility. Lead poisoning is merely one of the situations responsible for such dysfunctions.

As far as therapy is concerned, of course, the basic therapy is the use of chelating agents to rid the body of the toxic amounts of lead responsible for these manifestations. In the meantime, however, we may wish to treat some of the symptoms that occur secondary to hypertonicity and hypermotility. A logical approach would be to give a drug that will slow down this activity or diminish spasm, and such agents do seem to be quite effective. In most of the texts you will find intravenous calcium gluconate stated to be of frequently dramatic benefit, or atropine and atropine-like drugs recommended. Other smooth muscle relaxants, particularly papaverine are recommended, and we've been impressed with how frequently 60 mg. intramuscularly is able to relieve acute gastrointestinal spasm. In this case we did give two grains of papaverine I. M. on several occasions and the patient related to us that he got almost immediate relief of his cramping abdominal pains.

Dr. Kemp: I'd like to ask Dr. Ahlquist if he will go into the pharmacology of the chelating agents with us, and explain how these agents work in ridding the body of lead.

Dr. Raymond Ahlquist (Pharmacology): Before chelating agents became available, pharmacologists stood on the sidelines of the relative clinical controversy over whether you should de-lead or whether you should not de-lead the patient. As Dr. Kemp has stated, the lead in the circulation may either affect soft tissues and bring about toxic effects or may go into bone where it is relatively non-toxic. If suddenly you bring lead out of the bone you can induce acute toxicity. The debate was, therefore, as to whether when lead was demonstrated in the circulation it should be forced into the bone to become non-toxic or try to get it out through the kidney. Since lead and calcium are treated similarly by the body any of the procedures indicated by Dr. Kemp which deposit calcium in bone will also put lead in bone.

With a high calcium-high phosphate diet, lead is transferred from soft tissues to bone. With low cal-

Medical Grand Rounds

cium-high phosphate, lead and calcium are transferred out of bone. Acidosis produced by means of ammonium chloride will transfer lead out of bone into the circulation. Sodium bicarbonate (alkalosis) will also transfer lead out of the bone. The administration of parathyroid hormone will do the same. The administration of large doses of Vitamin D will transfer the lead from the circulation into bone. Dimercaprol (BAL®) will increase lead in urine apparently by releasing the lead from red blood cells. BAL® has no effect on the lead in soft tissues or bone.

Chelation is the process by which divalent metallic ions become bound by coordinate valence bonds and thereby become non-ionizable. Chelating agents have two electron-donor groups, such as thiol, hydroxy, amino, or carboxyl, in proximity. The agent used in this patient is ethylenediamine tetraacetic acid which is also known by the abbreviation EDTA, the generic name edathamil, and the trade name Versene®. One molecule of the tetra-sodium salt of EDTA will bind one molecule of calcium forming the chelate known as edathamil calcium disodium. This latter substance is used clinically in the treatment of lead poisoning.

Other metals will replace the calcium ion in this chelate. The metals can be listed in the following sequence: lead, copper, nickel, cobalt, zinc, calcium, iron, manganese, magnesium—which is the approximate descending order of affinity for the chelate bonds of EDTA. For example, lead will replace calcium. It should be noted that with the exception of lead all the other metals listed are needed in the organism. For example, iron is needed in hemoglobin, and the others are needed in a variety of enzyme systems.

If lead can be demonstrated in the blood, edathamil calcium disodium will chelate this and effectively remove it in the urine. Edathamil apparently cannot remove lead from either soft tissues or bone. It is comparatively non-toxic. It does not disturb serum calcium as does the tetrasodium salt. A possible danger to long-continued use of EDTA would be the possibility of removing necessary trace metals.

Dr. Kemp: The hematological manifestations of plumbism have been briefly mentioned in presenting this patient. Dr. Wright, would you comment further on these.

Dr. C-S. Wright (Medicine): There is generally a mild anemia associated with chronic lead poisoning. Lead evidently inhibits the proper formation of heme and this results in increased basophilic stippling of the RBC. These cells have a shortened life span and if the spleen is intact, they are given pri-

ority in their removal from the circulation. In experimental plumbism, more stippled RBC were seen in the splenectomized animals. The resultant anemia has a mild hemolytic component. The urine shows a marked increase in coproporphyrin III, this occurring earlier than the appearance of the basophilic stippling.

Dr. Moore: Actually, what is the basophilic stippling of the erythrocytes?

Dr. Wirght: Basophilic stippling is actually a young RBC or reticulocyte whose basophilic substance has been modified by the lead. It is seen to a greater degree in lead poisoning, but is not confined to this.

Dr. Thomas Findley (Medicine): I want to caution anyone who has a copy of a book by Thomas Cadawalader entitled "Essay on the West-India Dry Gripes" to cling to it carefully because it is one of the most valuable contributions to this subject ever made by an American physician. Cadawalader was a Philadelphian and his book was published by Benjamin Franklin in 1745.

Is continued urinary excretion of coproporphyrin a reliable indication for continued therapy? I understand that a qualitative test for it is a simple office procedure.

Dr. Avret: Demonstration of coproporphyrinuria is a relatively simple test. It may be used as a screening test for lead intoxication although it is not specific, for it is also found in liver damage, some infections, and blood dyscrasias. The test consists of acidifying five c.c. of urine followed by addition of two drops of hydrogen peroxide and five c.c. of ethyl ether. This is shaken well, allowed to stand for 10 minutes and examined under an ultraviolet light. A cherry red fluorescence of the ether layer indicates the presence of coproporphyrins. Incidentally, this patient became normotensive after treatment.

Resident: Do we know the source of the lead in this patient?

Dr. Kemp: This has been investigated at some length. The aluminum company for which the patient worked supplied an assay of the raw material used in the plant and supposedly there is no lead contamination. The only lead used in the plant is a pot of molten lead placed some distance from the patient's work area in which strips of aluminum are treated in order to facilitate bending. The patient's local physician reports he suspects lead contamination of locally produced untaxed whiskey, in as much as this has been implicated in the death of another man in the community recently.

Dr. Curtis H. Carter (Medicine): Interestingly enough, soda fountains have been cited as a source of chronic lead poisoning in the past. In the U. S. Navy certain prescribed standards have been speci-

fied as to the allowable lead content permitted in water passing through the pipes of these fountains.

Dr. Moore: How long can one expect to continue treating patients with chelating drugs? Is it apt to be six weeks or six months?

Dr. Ahlquist: The usual maximum dose is 2.5 grams per 4.5 kg. of body weight given at the rate of 0.33 gm. per 4.5 kg. per day. Not more than two such courses seven days apart should be used without a rest period.

Dr. Wright: It might be mentioned that the use of chelating agents to mobilize the iron in hemosiderosis has not been very successful.

Dr. Carter: Is there any danger of removing essential trace metals from the body through the use of chelating agents?

Dr. Ahlquist: It is possible that this might occur. However, the trace metals are present as chelates and may be so firmly bound that they cannot be transferred to edathamil.

Dr. Carter: Are there any available chelating agents for the use in treatment of arsenic poisoning?

Dr. Ahlquist: Arsenic does not form chelates. Therefore arsenic poisoning cannot be effectively treated with chelating agents.

Addendum

Since this Conference I had the privilege of discussing this problem with a bootlegger now a guest of the State in another institution. I inquired about the practice of adding old automobile batteries to the mash and was told that this is commonly done. When asked why, she said "Why, Doc, we puts the battery in because it strengthens the whiskey good and gives it such a piquant flavor."

Thos. Findley, M.D.

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SURVEY POINTS UP HOW MDS STAND WITH PUBLIC

A RECENT SURVEY by the Hartford County (Conn.) Medical Society on what local citizens think of their doctors indicated that while people approve of the quality of medical care they receive, they have other opinions about the cost of it.

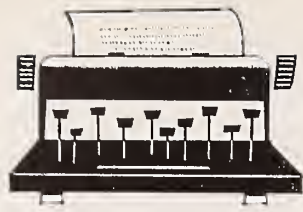
On the whole the survey turned by *favorable views on the availability of physicians* (81 per cent said they had never had trouble getting a doctor when they needed one) and the competency of their physicians (91 per cent felt that the care rendered by their family doctor was either good or excellent).

In the matter of costs, 77 per cent thought doctors' charges were about right for office calls and 70 per cent felt that current home call charges were reasonable. However *only 46 per cent considered surgical charges about right*, while 16 per cent (mostly in the lower income group) felt they were too high. More people

(43 per cent) disapproved of prescription prices than approved (39 per cent). Views on whether or not hospital costs were too high ran about 50-50.

Although the trend in recent years has been toward billing patients by itemized statement, 52 per cent of the sample indicated they did not receive itemized bills from their doctors while 39 per cent said they did. Strangely enough, only 28 per cent said they actually wanted their bills itemized.

One significant fact the survey turned up—and one which probably applies to other societies as well—was that only 40 per cent of the sample had ever heard of the Hartford County Medical Society. Most of those who had were in the upper income group. Even more disturbing was the fact that *83 per cent had never heard of the society's emergency call service* which indicates that a good deal of publicity is in order for this phase of the organization's activities.



editorials

Surgical Considerations in Cerebral Arterial Insufficiency

EVERY PATIENT WITH CEREBRAL arterial occlusive disease should be suspected of having a surgically curable lesion. To realize the full potential of this new and encouraging method of treatment the hopeless attitude of some physicians toward strokes must be replaced by an aggressive approach. Recent studies indicate that approximately 25 per cent of all patients with the stroke syndrome have segmental atherosclerotic obstructions in the extracranial arteries. The possibility of restoring normal pulsatile cerebral blood flow offers new hope to many patients who in the past have been known to have a dismal outlook.

The clinical features of cerebral arterial insufficiency are inconstant due to variations in the extent and rapidity of development of the collateral circulation. Many patients have occlusion of one or both carotid arteries without symptoms; in fact, on rare occasions one may find complete cervical occlusion of three of the four major arteries supplying the brain without any history of neurological deficit. In general, occlusion of one vertebral artery does not produce any symptoms; however, if both vertebral arteries are occluded, symptoms associated with basilar artery insufficiency ensue. Patients with complete or partial occlusion of the internal carotid artery may present a progressive, intermittent or sudden neurological deficit. At best the neurological symptoms and findings are inconstant; however, hemiparesis is the most common finding. The upper extremity is usually more paretic than the lower. Pathological signs associated with examination of the arteries are frequently stressed. Absence or di-

minution of common carotid and arterial pulsations in the upper extremities are always found in obstructions at the aortic arch—the so-called aortic arch syndrome. Since the internal and external carotid arteries are in juxtaposition, palpation for pulsations in the neck and pharynx is totally unreliable. Auscultation for bruits in the neck and head may be helpful when stenosis is present. One must remember that a bruit may be heard over the carotid artery when there is little or no obstruction of total blood flow. Ophthalmodynamometry has not been of much assistance in confirming the diagnosis due to the development of collateral circulation by the external carotid artery. Manual compression of the suspected normal carotid artery may lead to syncope or convulsion when the opposite artery is stenosed or occluded.

One can readily see that the diagnosis of cerebral vascular insufficiency cannot be definitely established on clinical grounds alone. DeBakey, Lyons, Crawford, and others believe that in order to establish this diagnosis and to rule out space-occupying lesions, such as a neoplasm or subdural hematoma, arteriography should be performed on all patients presenting the stroke syndrome. Due to recent advances and modifications in technic and the development of newer opaque media, most neurological centers agree with their advice. Today reactions are uncommon and of a minor nature. For carotid arteriography no more than 5 - 8 cc. of 50 per cent sodium diatrizoate (Hypaque®) is injected into the carotid artery via a Cournand arterial needle. Bilateral carotid arteriograms should

always be performed. The vertebral arteries are visualized by injecting Hypaque® into the subclavian arteries. If occlusions at the aortic arch are suspected, visualization of the arch may be obtained by inserting a needle through the suprasternal space of Burns directly into the aortic arch or by modifying the routine technic used in angiocardiology. All of these procedures can be performed under local anesthesia by the percutaneous route.

Once the diagnosis of cerebral arterial insufficiency due to obstruction of the vertebral or carotid arteries in the neck is established, the treatment of choice is restoration of a normal pulsatile flow of blood to the brain. Surgical correction should be carried out as soon after the stroke as possible since distal propagation of the thrombus frequently occurs. For success in using any of the usual surgical technics the obstruction must be segmental with relatively normal vessel proximal and distal to the

lesion. Another necessary criterion is that the brain tissue distal to the obstruction must be "sick" and not "dead." Unfortunately with our present knowledge it is impossible to tell the difference between "sick" brain tissue and "dead" brain tissue. Obstructions at the aortic arch can almost always be corrected by using a trifurcated plastic graft inserted in an end-to-side fashion. Obstructions in the internal carotid and vertebral arteries usually occur at their origins. Thromboendarterectomy alone, thromboendarterectomy with use of a plastic patch to prevent stenosis, insertion of a by-pass graft or resection, and end-to-end anastomosis or graft replacement are some of the technics which may be used to restore arterial continuity. The actual method used will depend upon the pathological anatomy and the preference of the vascular surgeon.

Milton F. Bryant, M.D.

Quackery and the Physician

A RESOLUTION ADOPTED by the MAG House of Delegates at the Annual Session in May urged all members to work with law enforcement officials in reporting non-licensed practitioners.

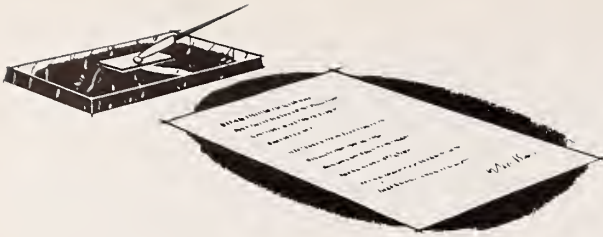
In the past, this has been very difficult to do. Many physicians have become discouraged after reporting a cancer quack when no action was taken by law enforcement officials. Frequently the response of officials is that "I haven't got anybody to investigate your complaint," or more frequently, "Will you or someone who has personal knowledge of this case, testify in court against the quack."

Lack of follow-up in quackery cases should not discourage us from continuing to bring these matters to the attention of the proper authorities. It is our duty as physicians to do so. We must continue to expose quackery, whether it occurs inside or outside the profession.

The AMA Code of Ethics, Section 4, states that "A physician should safeguard the public and itself against physicians deficient in moral character or professional competence . . . Physicians should expose, without hesitation, illegal or unethical conduct of fellow members of the profession."

In case you are in doubt, quacks are generally clever but give themselves away:

1. When they guarantee quick cures.
2. When they decry the use of surgery, drugs, or X-rays.
3. When they claim they have a secret or special machine or formula that cures disease.
4. When they advertise by using case histories and testimonials.
5. When they claim medical authorities are persecuting them.



abstracts by georgia authors

Vogler, Wm. R. and Powell, Ralph W., Emory University Hospital, Emory University, Georgia, "A Clinical Evaluation of Thermography and Heptyl Aldehyde in Breast Cancer Detection," *Cancer Research* 19:207-209 (Feb) 59.

Reports of measurable temperature elevations over malignant nodules in breasts, and the production of pain and lowering of temperatures following the injection of 1 cc. of pure heptyl aldehyde (850 mg) in the gluteal region, prompted the authors to attempt a similar study.

Skin temperatures were measured with a thermocouple over 17 malignant and 30 benign breast nodules. All diagnoses were confirmed histologically. No significant temperature differences were found.

Heptyl aldehyde was administered to seven patients with advanced cancer, four with metastatic breast (adenocarcinoma), two with metastatic melanoma, and one with bronchogenic carcinoma. The drug was given in doses as large as 2 cc. twice a day. Severe local irritation and rises in bromsufalein retention resulted. The livers of two autopsied patients revealed fatty metamorphosis and central focal necrosis, probably in part due to the drug. No beneficial effects were noted.

In no instance was pain produced in metastatic nodules. One patient with metastatic bronchogenic carcinoma to the scalp showed a 1.5° F. drop ten minutes after injection. He noted no pain in the nodules.

The authors concluded that thermography and heptyl aldehyde in the doses used were of no clinical use in the diagnosis or treatment of breast cancer.

Wolf, H. W., M.S.; Harris, M. M., Ph.D.; and Dyer, W. R., M.D., Communicable Disease Center, Public Health Service, Savannah, Georgia, "Staphylococcus Aureus in Air of an Operating Room," *J.A.M.A.* 160:1983-1987 (April 25) 59.

A series of observations on the occurrence of coagulase-positive strains of *Staphylococcus aureus* in the air of the main operating room of a hospital was climaxed by the development of a case of most operative sepsis in a patient who was operated upon while samples of the air were being taken. The organism isolated from the wound

was a coagulase-positive aureus of phage type 80/81. This same organism was isolated from the air during the operation by both slit (volumetric) and settling plate samples. Computations indicate a maximum density of aureus of 23 per 100 cubic feet and a settling rate of 26.5 per square foot per hour. None of the personnel of the surgical staff were found to be carriers (nares) of this phage type staphylococcus.

Only two members of the surgical staff were found to have a coagulase-positive *Staphylococcus aureus* in their nares based upon a single culture. The aureus from both these individuals was a non-typeable strain. Of the 3276.3 cubic feet of air sampled, only one aureus was isolated from the air which might have originated with either of these individuals based upon this phage pattern as well as the antibiotic sensitivity spectrum.

A light sweeping of the floor with a hair broom is sufficient to introduce many staphylococci into the air. When *Staphylococcus aureus* is found in the air, it sometimes occurs in showers, a factor which could be attributable to the patient or to extremely recent contact of the operating room staff with a source.

Harrison, J. Harold, 490 Peachtree Street, N.E., Atlanta 8, Georgia, "Synthetic Materials as Vascular Protheses—111, Long Term Studies on Grafts of Nylon, Dacron, Orlon, and Teflon Replacing Large Blood Vessels," *Surgery, Gynec & Obst.* 108:433-439 (April) 59.

Ten of an original group of 84 dogs with grafts of dacron, nylon, orlon, and teflon inserted into defects in the thoracic aorta were observed for periods up to three years.

Maintenance of patency was no problem as only one graft became occluded and this secondary to a hematoma.

There was unexplained delayed bleeding through the interstices of grafts of nylon, dacron, and orlon resulting in encapsulated hematomas.

Nylon continued to lose strength. Complete breakdown resulted with rupture in two grafts. Dacron, orlon, and teflon maintained most of their strength during the period of observation.

Grafts made of teflon were the only ones in which complications did

not occur when observed for two years. In addition teflon should, due to its greater chemical inertness, be expected to maintain its strength over a longer period of time. It is considered the synthetic material of choice as a vascular prosthesis and superior to homografts for replacing vessels larger than nine millimeters in diameter.

Ward, Dennis, E., M.D., 300 Boulevard N.E., Atlanta 12, Georgia, "Squamous Cell Carcinoma of the Floor of the Mouth, Alveolar Ridge, and Buccal Mucosa," *Am. Surgeon* 25:380-385 (June) 59.

Squamous cell carcinoma of the floor of the mouth, alveolar ridge, and buccal mucosa usually develops in an area of leukoplakia and in association with the use of tobacco.

Early radical surgery is the treatment of choice and preoperative radiotherapy is contraindicated. Adequate resection of mandible is extremely important. When no cervical metastasis is demonstrable suprahyoid dissection appears adequate, but when the reverse is true complete neck dissection is mandatory. Occasionally bilateral neck dissection is indicated. The functional result of hemimandibulectomy is good, the cosmetic result is not odious. When the lesion lies posteriorly slightly more than one-half of the mental process may be preserved which gives a better cosmetic result.

Plastic reconstruction at the time of resection is usually contraindicated. Radiotherapy cannot be depended upon for cure. There is no satisfactory method of palliation. The patient's age and general condition should very rarely preclude adequate surgery. Many patients die needlessly of this disease because their physicians fail to institute adequate treatment early enough.

These statements are based upon a review of the literature and a study of cases managed by the Sheffield Tumor Clinic at Georgia Baptist Hospital.

Hock, Charles W., M.D., and Lees, Brian, M.R.C. (London), Medical College of Georgia, Augusta, Georgia, "Pentobarbital Sodium—A Neglected Gastro-intestinal Antispasmodic," *Am. Pract.* 10:1015-1020 (June) 59.

Previous clinical experience led one of us (C.W.H.) to feel that pentobarbital

sodium would be an excellent barbiturate to employ for its direct antispasmodic and gastric inhibiting effects.

The efficacy of pentobarbital sodium and pentobarbital with belladonna in 463 patients having functional and organic disorders in the gastro-intestinal tract was studied and with only a few exceptions, all the patients were receiving other barbiturates and antispasmodics, without adequate relief of their symptoms.

Pentobarbital could be regarded as almost specific treatment for gastro-intestinal distress due to changes in bowel tone, "spasm", distention of the colon with gas, and similar causes. This does not imply that curative measures such as antibiotics or sulfa drugs were not employed when indicated, but rather that for specific relief of the presenting symptoms, pentobarbital alone or with belladonna proved far superior to other medications.

Cases included diarrhea, nausea, and vomiting due to many causes, nausea caused by intubation, acute episodes of "colon syndrome" in patients suffering from peptic ulcer, acute and sub-acute pancreatitis, and biliary colic.

The versatility of pentobarbital or pentobarbital with belladonna was significant—orally for severe nausea or diarrhea, pentobarbital rectally for vomiting and intramuscularly where oral and rectal forms were unsatisfactory.

Rooney, Donald R., M.D. and Powell, Waldo, M.D., Emory University School of Medicine, Atlanta 22, Georgia, "Carcinoma of the Thyroid in Children after X-ray Therapy in Early Childhood," J.A.M.A. 169:1-4 (January 3) 59.

Carcinoma of the thyroid in children is being diagnosed with increasing frequency. Several explanations have been offered to try to account for this increase. Among these is the formerly prevalent use of X-ray therapy for benign conditions such as "thymic enlargement" in infants. Many cases of so called "enlarged thymus" will disappear when adequate inspiratory chest films are made. The authors are in agreement with most pediatricians and radiologists who now believe that the thymus seldom, if ever, produces respiratory embarrassment or any other symptoms.

Thyroid neoplasia is a rarity follow-

ing radiation in adults, even when the thyroid receives many times the dose used to radiate an infant's thymus. In contrast to adults, 121 cases of thyroid cancer have been reported in children who have had previous radiation therapy. The authors present ten cases of thyroid carcinoma in children, 17 years old or younger, which represent all the recorded cases in this age group in Atlanta, Ga. Seven of these ten received previous X-ray therapy. Only 357 cases of childhood thyroid cancer have been reported and of these approximately one-third had received prior radiation therapy to the head, neck, or chest areas for non-malignant conditions.

If a carcinogenic mechanism is involved we should expect a decrease in the incidence of this neoplasm in the future, as the practice of irradiating benign childhood conditions decreases or ceases. Further studies are needed before definite conclusions can be reached. Until that time, children should be protected from all ionizing radiation, with few or no exceptions, in the treatment of non-malignant conditions.

Addendum: Since this article was published we have observed an additional child with papillary adenocarcinoma of the thyroid with cervical and pulmonary metastases. He is an 11 year old white male who had X-ray treatments for "enlarged thymus" ten years earlier. After this report was submitted 30 additional cases of thyroid cancer following X-ray therapy in childhood have been reported making a total of 152 cases.

Sikes, Z. S., M.D., 492 New Street, Macon, Georgia, "Stiff-Man Syndrome," Dis Nervous System 20:254-258 (June) 59.

This paper reviews the literature of a strange condition described and named Progressive Fluctuating Muscular Rigidity and Spasm (Stiff-Man Syndrome). A case so diagnosed was studied in considerable detail. Some aspects of the symptoms were so variable that a conversion basis was suspected. It was particularly noteworthy that the incapacitating symptoms were briefly completely ameliorated by hypnosis. A spinal fluid protein of only 38 mgs. per cent added further confusion in diagnosis. Spinal cord autopsy led to the discovery of the undiagnosed spinal cord tumor. The author suggested that this case particularly be used as an

illustration of how atypical neurological disease can be and how such typical symptoms can lead to erroneous diagnosis at the expense of the patient and to the embarrassment of the physician. Other possible explanations of the cases grouped under Stiff-Man Syndrome, the etiology of which was not explained, were proposed, giving the case studied as one example.

Brown, William J., M.D. and Sunkes, E. J., D.P.H., 1562 Deer Park Road, N.E., Atlanta 5, Georgia, "A Recent Study of the Results of Premarital Serologic Testing in a Southern State," South. M. J. 52:707-710 (June) 59.

The primary objectives of laws requiring pre-marital blood tests are (1) to find cases of infectious syphilis, treat them, and prevent spread; and (2) to find syphilis in its latent stages, treat, and prevent the occurrence of congenital or late manifestations. To evaluate the effectiveness of such laws, a study was undertaken by the Venereal Disease Branch, Communicable Disease Center, and the Georgia Department of Health, based on blood tests taken in public health laboratories in Georgia during the period January 1 - June 30, 1957.

Georgia's record system, which includes a query procedure to determine the diagnosis of reactive serologies in public health laboratories, was a factor in its selection for the study.

Of a total of 26,586 tests performed in public health laboratories during the six-month period, 814 (3.1 per cent) were reactive, or weakly reactive. Dispositions indicated that 215 cases (0.8 per cent of the number tested) were put under treatment for syphilis. This is a known minimum since it is based on only about one-third of the total known positive reactors on which disposition could not be ascertained.

In view of the recurring annual maintenance cost for hospitalization of the syphilitic insane (\$46,000,000) in addition to other economic losses due to disability and premature deaths due to syphilis, the study results in the recommendation that as long as pre-marital bloodtesting results in persons being placed under treatment for syphilis, there is definite indication for continuation of premarital bloodtesting. Further study on a current basis was recommended.

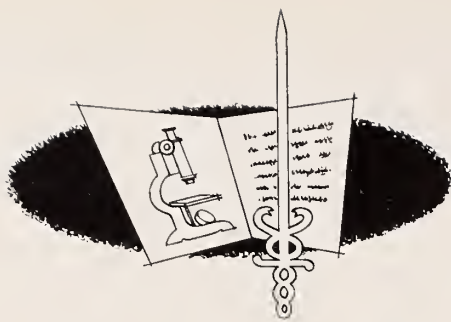
SILVER ANNIVERSARY MEETING

THE 25TH ANNUAL MEETING of the American College of Chest Physicians was held at the Ambassador Hotel, Atlantic City, June 3-7, 1959. More than 1800 physicians and guests attended the meeting. Fellowship certificates were presented to 210 physicians at the Convocation on Thursday, June 4. Honorary Fellowships were awarded to Dr. Harold S. Diehl, New York City, and to Mr. Murray Kornfeld, Founder and Executive Director of the College. Masterships were

conferred upon eleven past-presidents of the College.

Dr. Carl C. Aven of Atlanta was elected Historian for the College.

The following physicians from Georgia received their certificates of Fellowship in the College at the Convocation on June 4: James L. Alexander, Savannah; M. Bedford Davis, Jr., Atlanta; B. Shannon Gallaher, Augusta; James A. Kaufmann, Atlanta; and William H. Sewell, Atlanta.



cancer page

MOLES AND MELANOMA

EVERETT L. BISHOP, M.D., *Atlanta*

TO THE AVERAGE PERSON, almost any skin blemish is considered a "mole," whether it be actually pigmented or not, or a simple keratosis, a papilloma, a hemangioma, or the true "mole" or common pigmented tumor of nevoid character. Actually the term "mole" should be restricted to the latter type which is the true "nevus." It has been said that the average person has 27 "moles" of some type or other—some more, some less. Fortunately most moles of whatever type are benign. The natural history of the true mole or pigmented nevus is toward inactivity, regression, or fibrosis, although the pigment frequently remains as the visible evidence of a previously active growing tumor. Unfortunately, not all go through these regressive changes and may become increasingly active and eventually malignant.

True nevi are congenital tumors although many remain undiscovered until later in life due to the absence of visible pigment and it may not be until then when there is visible tumor formation and/or activation of melanogen into visible melanin that the tumor becomes evident. This is the main reason for the patient's statement that the "mole" has only recently developed or has been discovered.

Malignant Melanoma (melanocarcinoma; melanocarcinoma) is the malignant counterpart of the benign pigmented nevus. It may develop on the basis of a previously known nevus, or, as in some cases, ap-

parently appear as a rapidly growing malignant tumor right from the start. No individual or race is immune.

By far, the greatest number of benign and malignant "moles" appear as skin tumors, although these tumors may and can develop in many locations and tissues of the body. The various mucosae may be the primary site of highly malignant and fatal melanomas. Everyone knows and even the younger students have read of ocular melanoma and its metastasis (frequently long delayed) to the liver. Even the meninges may be the primary site and primary melanoma in lymph nodes has been suspected in certain cases, but melanoma involving lymph nodes is probably always metastatic, although the primary tumor may go undiscovered, or has previously been removed and long since forgotten. The true melanoma is a very malignant tumor, treacherous, and unpredictable, although the percentage of cures is rising, even up to 25 per cent in some series.

The main purpose of this short discussion is to express the personal opinion of the writer that *the best chance of cure is in the hands of the surgeon who first sees and removes the suspicious "mole."* Only about two per cent show any particular response to radiation therapy and these are almost curiosities. Therefore, *only surgical removal should be considered proper* in dealing with these malignant

Approved by Professional Education Committee, Georgia Division, ACS.

tumors. Any mole which shows evidence of active growth, or which is in such a location where it is subject to irritation or even more severe trauma, such as the neck, the belt line, the calf of the leg, etc., should be surgically removed.

No suspected melanoma should be biopsied but should be completely excised with a *wide* margin of normal tissue around the lesion and underneath. If the lesion is ulcerated and infected, it is perhaps permissible to do a biopsy for definite diagnosis and for planning suitable surgical procedure.

Too many of these tumors are removed with insufficient margins—a beautiful technical job but inadequate in dealing with such a highly malignant tumor. It is far better to remove an excess of normal tissue and even skin graft if necessary than to leave

foci of active tumor in the surrounding tissues as a source of recurrences and metastases which of course lower the chance of cure. If the margins are too narrow, or incomplete removal suspected, re-excision will be necessary, although in many of these cases, no trace of residual tumor can be demonstrated, yet it may be present in areas missed in the sections.

Space does not permit any discussion of dissection in continuity, routine lymph node dissection, etc., and frequently such procedures must be based upon the individual case, and upon the opinion of the oncologist. But in any case, in dealing with the primary tumor, it should be *wide* excision, skin graft if necessary, removing *all* of the tumor *with adequate margins of normal tissue*. What if there is a scar? It is infinitely better for the patient to live with a scar than to lose his life to “black cancer.”

NEW ORLEANS REPORTER TO GET MEDICAL TROPHY

IN A MOVE to encourage accurate reporting of medical news, the Orleans Parish (La.) Medical Society is contributing an annual medical news trophy to the list of awards presented by the New Orleans Press Club to newspapermen this year.

The society's PR committee will pass on the eligibility of entries on the basis of medical importance and accuracy. Winner of the award will be chosen by a nationally recognized science writer appointed by the Press Club.

1959 CALENDAR OF MEETINGS

State

- Oct. 9-10—Grady Hospital Clinical Society, Atlanta.
- Oct. 13-15—Medical College of Ga. and Medical College of Ga. Foundation's Postgraduate Course, Augusta.
- Oct. 14-15—GAGP Scientific Assembly, Wilmington Island, Oglethorpe Hotel, Savannah.
- Oct. 16—Georgia Diabetes Association Meeting, Wilmington Island, Oglethorpe Hotel, Savannah.
- Dec. 1-3—Medical College of Ga. and Medical College of Ga. Foundation's Postgraduate Course, Augusta.

Regional

- Sept. 28-29—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tenn.
- Oct. 16-18—The Potomac-Shenandoah Valley Postgraduate Institute, Shenandoah Hotel, Martinsburg, W. Va.
- Nov. 2-5—Twenty-seventh Annual Assembly, Omaha Mid-west Clinical Society, Civic Auditorium, Omaha, Neb.
- Nov. 16-19—Southern Medical Association, Atlanta.

National

- Sept. 13-17—International College of Surgeons, Chicago, Ill.
- Sept. 27 - Oct. 2—American College of Surgeons, Atlantic City, N. J.
- Sept. 28-Oct. 2—American College of Physicians, Postgraduate Course No. 1, Georgetown Univ. School of Medicine, Washington, D.C.
- Oct. 3-8—American Academy of Pediatrics, Chicago, Ill.
- Oct. 5-7—American College of Physicians, Postgraduate Course No. 2, Univ. of Buffalo School of Medicine, Buffalo, N.Y.
- Oct. 10—American Rhinologic Society, Belmont Hotel, Chicago, Ill.
- Oct. 15-17—The Academy of Psychosomatic Medicine, Sheraton-Cleveland Hotel, Cleveland, Ohio.
- Oct. 23-25—American Heart Association, Philadelphia, Penn.
- Nov. 2-6—American College of Physicians, Postgraduate Course No. 3, State Univ. of N. Y. Upstate, Syracuse, N. Y.
- Nov. 29-Dec. 2—National Society for Crippled Children and Adults, Chicago, Ill.
- Dec. 1-4—AMA Clinical Meeting, Dallas Texas.
- Jan. 21-23—American College of Surgeons, The Brown Hotel, Louisville, Ky.



THE SYNDROME OF BASILAR ARTERY INSUFFICIENCY

SAMUEL O. POOLE, M.D., *Gainesville*

DURING RECENT YEARS considerable attempt has been made to categorize the various cerebrovascular syndromes. Of particular interest has been that group of patients suffering from insufficiency of the basilar arterial system. Recent work suggests that recognition of this condition is of particular importance since many of the symptoms may be relieved by the administration of anticoagulants.

The basilar arterial system carries blood to the pons, mid brain, upper cerebellum, and through the posterior cerebral arteries to the occipital lobes. The symptoms and neurologic findings due to impairment in blood supply will depend on the location of the occlusion, whether it is gradual or sudden in onset, and whether or not an adequate collateral circulation is present.

Complete occlusion of the basilar artery is not too difficult to recognize but unfortunately it is usually rapidly fatal. The most striking localizing findings are flaccid quadriplegia associated with cranial nerve palsies. The patient is usually deeply comatose and has neither reflex nor voluntary eye movements. Episodes of extensor rigidity are extremely common. Death usually occurs after three or four days.

Of more importance than the above syndrome is the recognition of intermittent insufficiency of the basilar arterial system. Symptoms may be present for years before the fatal attack and are often incorrectly diagnosed as attacks of "cerebral vasospasm." These patients may have recurrent neurologic episodes which are quite fleeting, and often considered to be of minor significance. No individual

symptom can be considered characteristic but the pattern of a group of attacks may suggest the diagnosis. The most common symptoms encountered are recurrent episodes of weakness of one side of the body. This same symptom occurring on opposite sides of the body in definite attacks strongly suggest the diagnosis. They may also have recurrent episodes of vertigo, at times associated with vomiting. Periodic attacks of confusion, somnolence, dimness of vision, and dysarthria are frequently encountered. Transitory sensory loss involving one or both sides of the body is seen often. Episodes of numbness of one or both sides of the face or even both legs may occur. Numbness of one side of the body associated with paralysis of the other side always brings the diagnosis to mind. Episodes of diplopia are frequently seen. Cerebellar ataxia may occur and these attacks are difficult to evaluate and often in this situation it may be felt that the patient's symptoms are functional rather than organic. As seen from the above, the symptoms and signs will depend on the location of the ischemic zone, that is, whether it is in the pons, mid brain, cerebellum or occipital lobes. The cardinal signs of involvement of the brain stem is evidence of cranial nerve lesions combined with signs of long tract involvement.

Considerable evidence now exists to support the view that long term anticoagulant therapy may favorably modify the natural course of basilar artery insufficiency. There is no uniformity of opinion but certainly the work from the Mayo Clinic suggests that anticoagulants often terminate the recurrent

ischemic episodes. Since the difficulty is due to an occlusive atherosclerotic process and associated with a high fatality rate it is felt by many authorities that anticoagulants are definitely indicated. The mechanism of improvement following anticoagulants is poorly understood. Clinical studies plus the use of electroencephalographic testing on the tilt table suggest that anticoagulants may aid in improving collateral circulation but this is still unproven.

Any patient with transient episodes of cerebrovascular insufficiency should be carefully evaluated and each episode should be evaluated separately. Often there are many factors in each patient which contribute to transient episodes of decrease in cerebral blood flow which may precipitate an ischemic attack. Undoubtedly the maintenance of an adequate cerebral blood flow and a good "head of pressure" is important in these atherosclerotic individuals. These patients often have "systolic" hypertension and are

notoriously over treated with antihypertensive drugs. When their blood pressures are reduced these ischemic attacks often increase in frequency and severity. Hypotension whether occurring on the operating table, following dehydration or simply from arising from the recumbent to the erect position should be carefully avoided. Nitroglycerin in such individuals with this syndrome who have angina pectoris should probably be used in the sitting or recumbent position rather than in the erect position to avoid sudden fluctuations in blood pressure. Symptoms of mild heart failure should be searched for and corrected. Avoidance of prolonged standing and the use of elastic stockings and at times even abdominal binders may be of help in some individuals with these recurrent attacks. Over all this is a rather discouraging disease to treat but attention to minor detail can often give these patients some degree of improvement.

POISON CONTROL CENTERS SAVE LIVES, SUFFERING

EIGHT POISON CONTROL centers have been set up in hospitals in Georgia for service to physicians and other hospitals in treating cases of accidental poisoning.

Each center maintains 24-hour telephone service to answer questions from physicians on the ingredients of drugs and household supplies and to advise on appropriate treatment methods.

The centers have been set up with the assistance of the Georgia Department of Public Health, which acts as a state clearinghouse. A national clearinghouse conducted by the U. S. Public Health Service in Washington, D.C., has made available card files on about 600 trade-name products, not listed in reference books, that are potentially dangerous. These include household cleaning compounds, home medications, insecticides, and paints.

Each physician in Georgia has been furnished by the Health Department with a wallet-sized card giving

the location and telephone number of each poison control center in Georgia, and has received complete instructions on how to obtain information.

"Hundreds of new medicinal and household products come on the market each year," said Dr. Thomas F. Sellers, director of the Georgia Department of Public Health. "It is impossible for any one person or group of persons to be acquainted with all potential poisons. We hope these centers will save lives and suffering in Georgia."

These poison control centers are located in Albany at the Phoebe Putney Memorial Hospital; in Athens at the Athens General Hospital, in Atlanta at Grady Hospital; in Augusta at The University Hospital; in Columbus at The Medical Center; in Savannah at the Memorial Hospital; in Valdosta at the Pineview General Hospital; and in Waycross at the Memorial Hospital.

current clinical concepts

Vasopressor Therapy

RESTORATION OF THE systemic blood pressure to normal levels by vasopressor drugs may often terminate cardiac arrhythmias such as premature systoles, atrial and ventricular tachycardias, atrial fibrillation, sinus bradycardia and heart block when they are associated with hypotension.

Serious ventricular arrhythmias may be induced if the blood pressure is raised to excessive levels. Therefore, it is recommended that short-acting vasopressor agents be used because if the pressor effect becomes excessive, it can be terminated at once.

Herbert Gold and Eliot Corday—Vasopressor Therapy in the Cardiac Arrhythmias—N. E. J. Med. 260, No. 23, 1959, 1155.

Systemic Lupus Erythematosus

EVIDENCE OF RENAL involvement, even when the abnormalities of the urine were mild at first, was the most serious prognostic omen. . . .

Deaths in treated cases were due to renal failure or complications of corticosteroid therapy.

Robert P. McCombs and James F. Patterson—Factors Influencing the Course and Prognosis of Systemic Lupus Erythematosus—N.E.J. Med. 260, 1959, No. 24, 1204.

Bacteremia Following Cardiac Catheterization

THE OCCURRENCE OF fever after cardiac catheterization due to *Pseudomonas aeruginosa* bacteremia is described. The source of contamination was found to be the lumen of catheters and Tuohy adapters inadequately sterilized by benzalkonium chloride solution. This experience, as well as observations from the literature, suggests that disinfection with quaternary ammonium compounds is of limited usefulness.

Martin D. Shickman, Lucien B. Guze, and Morton L. Pearce—N. E. J. Med. 260, No. 23, 1959, 1166.

The Death of Enrico Caruso

CLINICALLY SIGNIFICANT is the author's research into the cause of death of Caruso, the great Italian opera star. Staphylococcus asserted itself 38 years ago to produce peritonitis via rupture of a perinephric abscess, secondary to pneumonia and empyema. This account makes good reading and is most appropriate during this "Staphylococcal-age."

Robert W. Prichard, M.D., S. G. & O., Vol. 109:No. 1, July, 1959.

Recurrences of Sydenham's Chorea

THESE DATA PROVIDE the first available evidence that Sydenham's chorea can follow infections with Group A streptococci by an interval longer than rheumatic polyarthritides and carditis, even in the absence of the latter manifestations and, indeed in the absence of "rheumatic activity."

Angelo Taranta—Relation of Isolated Recurrences of Sydenham's Chorea to Preceding Streptococcal Infections—N. E. J. Med. 1959, 260, No. 24, 1209.

Post Mitral Commissurotomy Syndrome

THE POST MITRAL commissurotomy syndrome is a clinical entity readily distinguishable from the active rheumatic state, and is characterized by recurrent fever and chest pain following mitral valve surgery.

Philip Lisan, M.D. et al.—Annals of Internal Medicine, vol. 50, No. 6, pp. 1352, June 1959.

The Medical College of Georgia and

The Medical College of Georgia Foundation, Inc.

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October 13, 14, 15, 1959

A practical review of the major disturbances in fluid and electrolyte balance.

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Guest Faculty:

DR. ELBERT P. TUTTLE, Emory University, and Director, Georgia Heart Association Laboratories for Cardiovascular Research, Grady Hospital, Atlanta

DR. JAMES D. HARDY, Chairman, Department of Surgery, University of Mississippi Medical Center, Jackson

DR. JAMES EDWIN WOOD, JR., Professor of Internal Medicine, University of Virginia, Charlottesville

FRACTURES IN GENERAL PRACTICE

December 1, 2, 3, 1959

The diagnosis and treatment of the more common fracture problems.

Coordinator: DR. FLOYD E. BLIVEN
Guest Faculty:

DR. WILLIAM F. ENNEKING, Director, Division of Orthopedic Surgery, University of Mississippi Medical Center, Jackson

DR. JACK HUGHSTON, Consultant, Georgia State Crippled Children's Division, Columbus

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MEDICAL ETHICS

AT A RECENT MEETING of the Executive Committee of the Council of M.A.G. in which a discussion of medical ethics took place, it was felt that a certain vagueness and misunderstanding existed regarding some aspects of ethics. In an attempt to clarify the situation to some extent, the President was asked to discuss some phases of medical ethics, and to bring the membership up to date on recent A.M.A. action. The writer considers the following points of importance:

1. "Each individual should be accorded the privilege to select and change his physician at will." This freedom of choice of physician was reaffirmed by the House of Delegates of the A.M.A. at the 1959 convention. An adherence to and acceptance in good grace of this principle by physicians will do much to eliminate bitterness and antagonism between members of the medical profession. Certainly, it is not in the best interest of the patient or physician if dissatisfaction or loss of confidence exists; the physician-patient relationship is best terminated without ill-will on anyone's part. However, a consultant may not take charge of a case without the express consent and agreement of the physician requesting the consultation, and should a physician take care of a patient of another physician in the absence of his colleague, he should return this patient to the colleague at the earliest possible moment.

2. As a corollary to freedom of choice of the patient, "a physician may choose whom he will serve. In an emergency, however, he must render service to the best of his ability. Having undertaken the care of a patient he may not neglect him, and may discontinue his care of the patient only upon discharge or after giving adequate notice."

3. "A physician may not reveal confidences entrusted to him in the course of medical attendance." This point was the subject of a resolution brought to the House of Delegates at the 1959 M.A.G. convention, and requires some clarification. If a patient has medical insurance, he has signed in his insurance contract permission to give information necessary for the settlement of claims, and express permission from the patient is not necessary. Likewise, a certain



Luther H. Wolff

LUTHER H. WOLFF, M.D.,

President, Medical Association of Georgia

PRESIDENT'S LETTER / Continued

amount of judgment and common sense must be used in conveying information to members of the patient's immediate family. However, requests for information from curious friends and distant relatives are best answered, I believe, in a noncommittal manner. Any request for information from insurance agents or lawyers not having a contract with the individual should be accompanied by the express written or oral consent of that individual.

4. "A physician may not solicit patients." The solicitation of patients directly by advertisement or by arrangements with insurance adjusters, etc., is practically never encountered at present. However, indirect solicitation by referral, a sort of you-scratch-my-back-and-I'll-scratch-yours arrangement, is not uncommon. In the final analysis, any arrangement that infringes upon the freedom of choice of the patient is not to be condoned.

5. "A physician should expose, without fear or favor, incompetence or corrupt, dishonest or unethical conduct on the part of members of the profession." Needless to say, questions of this nature should be first considered by medical tribunals such

as grievance committees, boards of censors, or professional conduct committees.

6. Fee splitting, or any device such as "kick-backs," discounts, loans, favors, gifts, and emoluments, with or without the knowledge of the patient, are considered unethical. Physicians should always render separate bills for services rendered. The collection of a fee by one physician for another in a mutual case is not ethical. Fee arrangements on a contingent basis are unethical.

7. A physician should not voluntarily associate professionally with cultists.

8. A physician should not disparage to a patient, either by comment, insinuation, or by innuendo, another physician's methods or results. To do so lowers the confidence of the patient in the medical profession and so reacts against the patient, the profession, and the critic.

Your correspondent admittedly cannot discuss all phases of medical ethics in this letter. The reader is referred to the June 7, 1958, Special Edition of the Journal of the A.M.A. for further enlightenment and information. I have, however, tried to bring out points in ethics that confront us from day-to-day, and are therefore considered of importance.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and Members of the Committee:

As Dr. Larson has told you, the medical profession is opposed to H. R. 4700, 86th Congress, now pending before this Committee. Before presenting my statement, I should like to thank the Committee on behalf of the American Medical Association for the opportunity to testify.

The fundamental and over-riding reason for the opposition of medicine to this legislation is that it would, in our opinion, result in poorer—not better—health care for the people of this country. The American Medical Association's objective is—and always has been—to work toward the better health of Americans of all ages.

We are for all proper courses of action which will help us attain that objective. We are against any course of action which hinders or prevents its attainment.

As a doctor, it is my daily responsibility to help the aged—to treat them; to help them help themselves. And believe me, gentlemen, one of the best ways to

understand the problems of the aged is to serve them as a physician.

It has been by experience that the aged want just about the same things that all the rest of us do: to be part and parcel of their environment; to feel that their skills and talents have value, and can still be used; to be productive; to be loved; to belong.

There is no doubt about it: the problems of the aged are far broader than those of health alone.

Consider, for example, the field of employment, where compulsory retirement policies often undermine the individual's ego, his will to live, his feeling of usefulness.

Able and anxious to work, he frequently finds his abilities no longer in demand. Unnecessarily placed on the shelf, he feels as if he has been cashiered out of the human army without rank, weapons, medals, or identification.

The public fails to realize that the older citizen continues to have many special needs—in the field of housing; in recreation; in finding acceptance and understanding within the community. He also needs

Statement of the American Medical Association regarding H. R. 4700, 86th Congress, to the Ways and Means Committee, U. S. House of Representatives by Frederick C. Swartz, M.D., July 15, 1959.

preparation in advance, if his added years of life are to be full and rewarding.

These are not health problems, but they bear on health. And until society recognizes this, it will continue to consider in a piecemeal, hit-or-miss way a problem that requires a broad, total approach.

Concern for these problems animates all thoughtful people. I can assure you that the doctors of the country are concerned. For they know, as well as any group, that behind the array of statistics are individual men and women—that while each human being is alike, each is also very different.

And so when physicians hear broad statements about the problems of the aged, when they are asked to consider the across-the-board solutions that are proposed, they tend to apply the acid test of personal experience.

Would these proposed solutions really work? Would they really help the people whom the doctor serves, the individual patients whose problems and needs he knows so intimately?

It is by this yardstick that the physician measures his reply. It is by this yardstick that the members of the medical profession have formulated their position with respect to H. R. 4700 and similar bills.

Why Forand Bill Is Impractical

I would like to discuss some of the fundamental reasons why we believe that this proposed legislation is neither practical nor realistic.

Medical care is not susceptible to production-line techniques.

Care for any segment of our population—the aged included—calls for a cooperative attack on the problem by nurses, doctors, hospitals, social workers, insurance companies, community leaders, and others. It requires flexibility of medical technique—an ingredient which would unquestionably vanish the moment government establishes a health program from a blueprint calling for mass treatment.

If we abandon the community approach in favor of a rigid national health program we will, in effect, have constructed another Procrustes' bed. The mythological Procrustes, you will remember, developed a bed that was just the right size for everybody. There was only one trouble with it:

Procrustes, instead of altering the bed to fit the person, altered the person to fit the bed.

He accomplished this feat of legerdemain by trimming off the legs of the tall, and stretching the shorter victims on the rack.

I am sure we all agree that it is sounder to tailor the bed to fit the patient.

In the case of the aged, their health problem primarily involves acute illness and the so-called degenerative diseases. In a very large percentage of cases, the main need is not for an expensive hospital stay or a surgical operation, but for medical care at home or in the doctor's office. In other cases, the important requirement is nursing care in the patient's home, or the home of relatives. And in still others, custodial care in a nursing home or public facility may be the only answer. The point is that the medical needs of this particular segment of the aged are subject to countless variations. Any workable system of care must

be tailored to meet these variations. An example of a faulty program is the mass attack approach that has been forced on medicine in the handling of the mentally afflicted. They are removed from society but their medical problems have not been solved.

If H. R. 4700 were enacted, it would mean that the Federal government would finance the health care of OASDI beneficiaries through compulsory and earmarked taxes; the Federal government would control disbursement of funds; the Federal government would determine the benefits to be provided; the Federal government would set the rates of compensation for hospitals, nursing homes, dentists, and physicians; the Federal government would audit and control the records of hospitals, nursing homes, and patients; and the Federal government would promulgate and enforce standards of hospital and medical care.

When government at any level guarantees services which it cannot itself provide, it inevitably tends to control the purveyors of those services. I doubt that anyone here intends or seeks such control, but there is no doubt that it would take place.

Disclaimers notwithstanding, if a single government agency were to buy 10 to 20 per cent of all care in the nation's general hospitals, it would be utterly impossible to limit that agency's power to influence the over-all operation and management of hospitals.

One predictable consequence of such a national program would be the overuse and overcrowding of our hospital facilities. It is certain that a substantial increase in hospital use would result during the first year of this proposed program—simply because a government plan had been put into operation.

As doctors, we believe that patients should be placed in hospitals, nursing homes, and other institutions only when necessary. We believe the length of their stay, as well as the therapy rendered, should be dictated only by their medical condition and not by limitations of legislation or regulations.

The problem is far more than a matter of economics, or even of medical technique. We must also deal with the human spirit, which flourishes best in those who are determined to stay in the mainstream of day-to-day living.

Further Bad Effects

H. R. 4700 would have further bad effects:

—It would curb community incentive to support hospitals, for the tendency would be to shift this responsibility from the shoulders of private and local governmental sources to the already overburdened shoulders of the Federal government.

—It would discourage, at the community level, the freedom to experiment with new techniques, such as home care programs, day hospital service, homemaker services, progressive patient care, and new concepts for treatment through outpatient departments and doctors' offices. It is at the community level that such innovations are developed and made to work.

—It would discourage families from taking care of their own.

—It would restrict beneficiaries in their choice of hospital and physician. For only those physicians, and those hospitals and nursing homes entering into agree-

STATEMENT BY AMA / Continued

ments with the Federal government, would participate.

—The professional relationship between the doctor and his patient—the basis of all effective health care—would be severely handicapped. Government regulation would be imposed on the physician, and on the patient as well, bringing a third and intruding party between them. Required conformance to administrative regulations could also hamper the physician from prescribing treatment which, in his professional opinion, was indicated.

—It would discourage the individual approach to patient care. When this has been disregarded in the past, the result has been mass tragedy rather than mass cure.

—It would attempt to chart a health program for the aged without accurate knowledge of the problem's dimensions. The statistics presently available on the subject are neither conclusive nor complete. To use them as the basis for so far-reaching a program is akin to prescribing for the patient without first making a diagnosis.

Basically, H. R. 4700 simply proposes a form of national compulsory health insurance. For the moment, it would be limited in scope; however, there are many who are testifying before this Committee this week who admittedly seek to extend the program to every segment of the population. It should be remembered in this connection that, if the Federal government at some future date adopts a medical care program for the total population, it will be assuming a medical bill of more than \$20 billion annually. A report published by the Department of Health, Education, and Welfare, based on 1957 statistics, indicates that private health care costs approximately \$15 billion and that public and philanthropic costs amounts to about \$5 billion annually.

The bill would establish a dangerous precedent. Instead of cash benefits, it proposes service benefits irrespective of need. In effect, the Federal government would furnish the beneficiary with compulsory hospital and surgical insurance whether he needed it or not, whether he wanted it or not.

In this connection, let me say that the A.M.A. has never opposed the Social Security Act *per se*. H. R. 4700 is, however, a major and dangerous deviation from the original concept of the system.

We must also face the fact that any single program of health care for the aged should not embrace every aged person. The pending bill would cover millions of people who do not need or want government medicine.

Further, it is a misconception to think that this measure would aid those who receive Public Assistance, the vast majority of whom are not covered by Social Security. These indigent are now receiving their medical care through welfare programs. Aside from the help they get from many private, fraternal, and religious organizations, the indigent now receive more than \$4 billion annually in federal and state aid for medical and other expenses.

I should like to comment briefly on what this proposed legislation would cost.

It would be staggeringly expensive. The costs of this program during its first and second years have been estimated as in excess of \$2 billion a year, a

figure which can be expected to increase during the ensuing years.

There is absolutely no way of predicting the cost of H. R. 4700 in the years ahead. These programs expand. They never contract. Once they are on the books, they are there to stay.

Yet the problem of financing health services for the aged is a temporary, not a permanent one. As Dr. Larson indicated, voluntary health insurance is making tremendous progress, through expanded coverage and broader protection.

Dozens of different type policies are now available. Among them are policies guaranteed renewable for life; policies to cover those now over 65; coverages that will continue after retirement; and group policies that may be converted to individual coverage upon termination of employment.

Much Progress Has Been Made

Much of this progress has been made in just a few years. This indicates that the hospital costs of our aged are being met, in a large measure, by prepayment plans and insurance, as they steadily gain experience in this relatively new field of coverage.

Much progress is also being made in the development of new and improved facilities specially tailored to the particular health requirements of the older citizen.

As a part of this program, the A.M.A. has supported a loan program of the F.H.A. type for non-governmental hospitals and nursing homes, whether of a non-profit or proprietary nature. It has also recommended changes in the Hill-Burton Act to help the individual states earmark more money for non-profit nursing homes.

The A.M.A. continues to back further experiments in progressive hospital care; home care programs; and homemaker services, all of which have the common purpose of improving the quality of medical care by reducing the length of hospital and nursing home confinement through the earlier discharge of patients.

The record shows that sustained and heartening progress is being made throughout the United States toward meeting the needs of our older citizens promptly and positively.

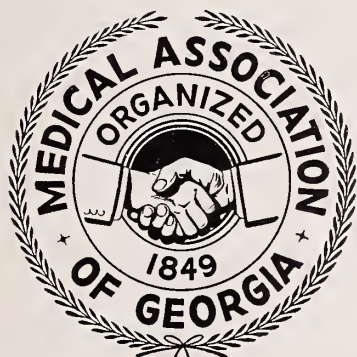
I do not have the time to specify here the details of the massive job that is being done. The fact is that voluntary methods—supported by the cooperative effort of many thousands of our citizens—are meeting the challenge and will continue to meet the challenge, given the continued opportunity.

So that this Committee has at its disposal the American Medical Association's six-point program for older citizens, we are appending a discussion of that program which I had the privilege of giving last month before the U. S. Senate Sub-committee on the Problems of the Aged and Aging.

In closing, one fact seems to me to be crystal clear: The health professions and other private voluntary groups are meeting the challenge. We believe that the same people who made this the healthiest nation in the world's history, and helped bring the gift of longer life to millions of Americans, are equipped to meet the problem of caring for the health of our older citizens.

1960 Annual Session

May 1-4, 1960 — Municipal Auditorium, Columbus, Ga.



First Call

for

Scientific Papers

All titles must be submitted to the respective
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November 1, 1959.

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St. Francis Hospital, Columbus

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S. A. Roddenbery
711 Center Street, Columbus

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Franklin D. Edwards
1430 Center Street, Columbus



the association

ANNOUNCEMENTS

The Medical College of Georgia and Medical College of Georgia Foundation, Inc. present their Fall Post-graduate courses. A course on "Electrolytes" will be offered October 13-15, 1959 and a course on "Fractures In General Practice" will be offered December 1-3, 1959. \$50.00 will be charged for each session. Each course is acceptable for 18 hours credit, Category I, by the American Academy of General Practice. A block of rooms has been reserved at the Medical Center Motel on Gwinnett Street across from Talmadge Hospital. Reservation Cards will be sent direct to the registrants with a letter confirming acceptance to the course. Meals will be available in the immediate area. All correspondence should be addressed to: Dr. Claude-Starr Wright, Department of Continuing Education, Medical College of Georgia, Augusta, Georgia.

The Fourth National Cancer Conference sponsored by the American Cancer Society, Inc. and the National Cancer Institute will be held in Minneapolis, Minnesota, September 13-16, 1960. For further information write: Medical Affairs Department, American Cancer Society, 521 West 57 Street, New York 19, N. Y.

The American College of Physicians announces its postgraduate courses for autumn and winter, 1959-1960. Course No. 1, Selected Topics in Internal Medicine, September 28-October 2, 1959, Georgetown University School of Medicine, Washington, D. C.; Course No. 2, Selected Subjects in Internal Medicine, October 5-7, 1959, The University of Buffalo School of Medicine, Buffalo, N. Y.; Course No. 3, The Science of Internal Medicine, November 2-6, 1959, State University of New York Upstate Medical Center, Syracuse, N. Y.; Course No. 4, Clinical Cardiology, November 30-December 4, 1959, Tulane University School of Medicine, New Orleans, La.; Course No. 5, Current Concepts of the Rheumatic Diseases—Their Recognition and Management, January 11-15, 1960, Cornell University Medical College and the Hospital for Special Surgery, New York, N. Y.; Course No. 6, Internal Medicine—Selected Subjects, January 25-29, 1960, Henry Ford Hospital, Detroit, Mich.; and Course No.

7, Recent Advances in Metabolic Diseases, February 8-12, 1960, The Mount Sinai Hospital, New York, N. Y. For further information write to: The American College of Physicians, E. R. Loveland, Executive Secretary, 4200 Pine Street, Philadelphia 4, Pa.

Announcement is made of the Twenty-Seventh Annual Postgraduate Sessions of the Omaha Mid-West Clinical Society. Meetings will convene in Omaha's Civic Auditorium, November 2-5, 1959. All licensed physicians holding the degree of Doctor of Medicine may register for the assembly and thereby become Associate Members of the Society for the current year. For further information write to: Omaha Mid-West Clinical Society, John H. Brush, M.D., Director of Clinics, 1613 Medical Arts Building, Omaha 2, Nebraska.

Fourteenth Annual Course, Clinical Cardiopulmonary Physiology, Edgewater Beach Hotel, Chicago, Ill., October 5-9, 1959; *Twelfth Annual Course on Diseases of the Chest*, Park Sheraton Hotel, New York, N. Y., November 9-13, 1959; and *Fifth Annual Course on Diseases of the Chest*, Ambassador Hotel, Los Angeles, Calif., December 7-11 will be presented by the American College of Chest Physicians. For further information write to: Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Ill.

DEATHS

JAMES A. BUSSELL, 86, of Rochelle, died July 15. Dr. Bussell was a native of Dooly County but resided in Rochelle most of his life.

He was a member of the Rochelle Baptist Church, a member of the Medical Association of Georgia, and a member of the Rochelle Masonic Lodge for over 50 years.

Survivors include his wife; one son, James A. Bussell, Jr., Rochelle; three daughters, Mrs. H. P. Phelps, Ocilla, Mrs. H. W. Williams, Thomaston, and Mrs. S. L. Tankersley, Reynolds; one sister, Mrs. Minnie

Graham, Tifton; ten grandchildren; and 22 great grandchildren.

KENNETH S. HUNT, 68, a physician in Griffin for 40 years, died July 28 at St. Joseph's Infirmary, Atlanta.

Dr. Hunt was graduated from Vanderbilt University in 1915 with his Doctor of Medicine degree.

He entered the Armed Forces in 1918 and was commissioned a first lieutenant in the Army Medical Corps.

Dr. Hunt was a member of the Southeastern Surgical Congress, Fellow International College of Surgeons, Georgia Urological Association, American Medical Association, Medical Association of Georgia, and the Spalding County Medical Society. For many years he served as counselor for the Fourth District Medical Society.

Dr. Hunt was appointed to the City Board of Education to fill an unexpired term and served continuously since the appointment. He was on the staff of doctors employed by the Southern Railroad and a member of the board of directors of the American Cancer Society.

Dr. Hunt was a charter member of the Griffin Rotary Club. He was elected Man of the Year in 1956 by the Griffin Exchange Club in recognition of his long and outstanding service and leadership in Griffin and Spalding County. He was a member of the Griffin Lodge of Elks, First Methodist Church, and had been president of the Griffin Hospital Care Association since 1938.

Survivors include his wife; two sons, Kenneth Stovall Hunt, Jr., San Antonio, Tex., and Dr. Thomas Jefferson Hunt, Atlanta; three sisters, Mrs. Frank Hacker, Rutherford, N. J., Mrs. James R. Ivey, Milner, and Mrs. P. W. Moore, Maryville, Tenn.; and four grandchildren.

JOHN W. MAYHER, Columbus, died at the age of 50, July 11.

Dr. Mayher, who had lived here for the past 26 years, was a native of Sulphur Springs, Texas.

He was a graduate of the University of Mississippi and Northwestern Medical School.

Survivors include his wife and his father, both of Columbus; three daughters, Miss Dorothy Illges Mayher and Miss Margaret Shannon Mayher, both of Columbus, and Mrs. R. M. Ward, Arlington, Va.; a son, John W. Mayher, Jr.; a sister, Mrs. Arthur Sutherland; and a brother, Dr. William E. Mayher, all of Columbus.

THOMAS G. PEACOCK, SR., superintendent emeritus of Milledgeville State Hospital, died July 13 at the age of 63.

Born in Cordele, Dr. Peacock was graduated in 1915 from the University of Georgia. He graduated from Harvard Medical School in 1920.

He practiced in North Carolina, New Hampshire, and New Jersey before joining the medical staff of the

huge Georgia mental institution in 1947. He was named superintendent two years later.

Dr. Peacock, a Methodist, was a member of various medical groups, including the American Psychiatric Association.

Survivors include his wife and three sons, Thomas G. Peacock, Jr., Macon, Charles F. Peacock, McRae, and Stephen Peacock, Milledgeville.

SOCIETIES

The **DEKALB COUNTY MEDICAL SOCIETY** has appointed an advisory committee to aid and advise the Hospital Authority on various professional matters regarding the organization of the DeKalb General Hospital.

EMANUEL COUNTY MEDICAL SOCIETY had as its guest speaker Dr. Charles Brown, District Health Commissioner.

The doctors of the **SOUTHWEST GEORGIA MEDICAL SOCIETY** are joining in a statewide campaign to get the public immunized against polio.

Dr. Robert Gordon Ellison, heart and chest specialist, Talmadge Memorial Hospital, Augusta, delivered a scientific paper on his work in cardiovascular surgery to the **WARE COUNTY MEDICAL SOCIETY**.

What can be done for the cancer patient today and ways to improve treatment methods were studied by the **FOURTH DISTRICT MEDICAL SOCIETY** recently at Pine Mountain.

The **TENTH DISTRICT MEDICAL SOCIETY** held its annual summer meeting at the Community Center in Union Point.

PERSONALS

First District

LEE HOWARD of Savannah has been elected to the State Medical Education Board.

A. H. CENTER, Savannah, explained the uses of hypnosis to the Sertoma Club in Savannah recently.

C. E. POWELL, Swainsboro, was recently appointed a lieutenant colonel of the Governor's Staff by Governor Ernest Vandiver.

Governor Ernest Vandiver recently appointed **H. WILDER SMITH**, Swainsboro, an admiral of the Georgia Navy.

Second District

RICHARD C. PARSONS, formerly of Atlanta, has

announced his association with the Eye, Ear, Nose, and Throat Clinic in Moultrie.

ERNEST F. DANIEL, formerly of Augusta, has been added to the specialists on the medical staff at Phoebe Putney Hospital in Albany.

Third District

LUTHER H. WOLFF, Columbus, has been elected to the State Medical Education Board.

H. E. WEEMS, JR., Perry, was recently elected chief of staff of the new Houston County Hospital.

J. A. THRASH, Columbus, was guest speaker at the Columbus Kiwanis Club at the Ralston Hotel.

Fourth District

JOEL E. COX, formerly of LaFayette, La., recently moved to Griffin.

EMORY PARK of LaGrange presented a paper on methods of diagnosing heart ailments to the Lions Club of LaGrange.

ED T. ARNOLD, Hogansville, has announced that his office is now located at his home on East Main Street.

Fifth District

J. C. TANNER of Atlanta has been named chairman of the State Medical Education Board.

The newly-organized Newton County Mental Health Association held its first general meeting recently at which RIVES CHALMERS of Atlanta was guest speaker.

ROBERT SHINALL of Decatur has returned from New York and opened his office in the Medical Arts Building where he will practice dermatology.

CHARLES M. SILVERSTEIN of Atlanta has announced the opening of his office for the practice of diagnostic radiology.

Sixth District

JAMES H. HUNT, formerly of Mt. Vernon, has moved to Dublin and is now affiliated with J. ROY ROWLAND, JR.

DAVID E. QUINN of Dublin was presented a plaque of appreciation by the DAV's, the American Legion, the Amvets, and VFW. Dr. Quinn is now the new manager of the VA Hospital in Cleveland, Ohio.

Seventh District

IVAN ELDER, formerly of Columbus, has joined the staff of the Bremen Medical Clinic and Bremen General Hospital.

FRANK L. O'CONNOR of Rossville has opened his offices on Howard Street.

W. HARVEY HOWELL of Cartersville has been elected president of the Cartersville Rotary Club.

Eighth District

HERMAN DISMUKE of Ocilla has been elected vice chairman of the State Medical Education Board.

Ninth District

ROBERT T. CAIN, formerly of Gainesville, has returned to Clayton and is affiliated with GEORGE BOYD and CECIL TOOLE.

Tenth District

J. C. BOHORFOUSH, Veterans Administration medical specialist of Augusta, recently addressed a scientific and clinical conference in Miami Beach, Fla.

C. LATANE HAMILTON, formerly of Augusta, has opened offices in Winter Haven, Fla.

HAROLD CARSON, formerly of Chatsworth, has opened offices in Madison.

J. HUBERT MILFORD of Hartwell has been elected to the State Medical Education Board.

WALTER A. VOYLES has resigned from the full time faculty of the Department of Surgery of the Medical College of Georgia at the Eugene Talmadge Memorial Hospital in Augusta and will enter private practice of surgery in Waynesboro.

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COVER

Photograph taken at the Henrietta Egleston Hospital for Children, Atlanta, Georgia, by Mr. Joe Jackson, Department of Illustration, Emory University, Atlanta, Georgia.

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CARDIOVASCULAR DISEASE IN THE LIGHT OF THE LONG FOLLOW-UP

Paul Dudley White, M.D., *Boston Massachusetts*

Optimism is stressed in this account of the author's detailed follow-up of many cases with a presumed poor prognosis.

ONE OF THE MOST important and neglected aspects of medical practice, teaching, and research is that of the long clinical follow-up of patients of many categories and I am sure that most of us are guilty of sins of omission in this respect. It is certainly true in my own experience. One becomes so involved in duties of the present and plans for the future that he fails to carry out his obligations and opportunities for obtaining vital information by this relatively simple, although sometimes time-consuming, method of study. In my own situation, my errors of omission are frequently emphasized by meeting in my own community or in the U.S.A. elsewhere or in other countries, old patients of mine seen as long ago as several decades who remind me of our past acquaintanceship and report to me about their present health and intervening medical history. Happily, I carry in my pocket a little Memindex book in which I at once jot down follow-up notes. Just recently this happened to me several times on travels in Africa.

Of course, what one should do is actually to have a system by which, annually at least, patients should be inquired about, especially those of unusual nature or very ill, if one has lost contact.

I would like to interpolate here quotations from an editorial which I prepared for the *Journal of*

Chronic Disease three years ago (January 1956, Volume 3, pages 104-106).

"It is generally agreed that a vital part of the study of chronic disease is the long follow-up. Despite this obvious fact, the long follow-up is one of the most neglected of our research tools. There are several reasons for this which need more adequate attention than they have received.

"Commonly in the past, and not rarely even now, quite wrong or at least incomplete conclusions have resulted from the short-term study of patients over periods of weeks or months or even a few years, no matter how elaborate the so-called vertical investigation. Invaluable as much of the immediate or short-term study of disease has proved to be, many questions can be answered only by the long follow-up. . . .

"An important reason why the long follow-up has been so often neglected in the past is that many of the professors of medicine in the medical schools of the country and many of the clinical researchers are more or less peripatetic, progressing from one post and city to another as positions of academically higher importance present themselves. Since these are the individuals who do most of the medical writing, the studies which they report are, for the most part, of relatively acute conditions or, at best, over a few years only, so far as their own observations go, and in impersonal public clinics. The practicing physicians who follow many private patients, often very carefully, for many years in one locality are for the most part silent. It would be a great service to medical progress if the more carefully and better trained practicing physicians could present the more valuable long follow-up studies of their per-

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sonal patients. We should all make a more concerted effort to bring this to pass. As everyone knows, it is much easier and more productive to follow private patients, no matter what their social and economic status, than to follow so-called public patients in the clinics, although there are, of course, exceptions. . . .

"It is not an easy or simple matter to conduct a follow-up study of many patients over periods of many years in a satisfactory manner. Too often, councils, committees, and individuals responsible for the material or moral support of research have indiscriminately rejected application for funds for follow-up studies on the basis that they are a part of the routine care of patients. Sometimes this is true or in part true, but often it is not. A much more careful appraisal of each application should be made than has been the custom in the past. Questions should be asked in each case concerning several points: first, the need of the follow-up, which of course varies greatly from case to case; second, the ability, in this regard, of the investigators; third, its magnitude and, hence, its expense, also of wide variety; and fourth, the possibility or indeed, not rarely, the probability that it cannot be done without outside support.

Technique of Long Follow-up

"Finally, a word or two may be helpfully added as to the technique of the long follow-up. It is well to introduce the idea to the patient on the occasion of first meeting him, even though, at the moment, there is no serious disease to be treated. The intervals between re-examinations may be long, even up to five years, although I have found that annual checkups are the most satisfactory in maintaining contact with patients for the long follow-up. If, for one reason or another, intervals of years elapse and the patient moves away or dies, there are various methods that may be used to trace him. The family

doctor or some relative may have the needed information. If not, one may have to resort to the departments of vital statistics in the state and city or town where the patient once resided. One may enter a note of inquiry in the local newspapers, or even in the journals of a larger city whither the patient or some relative or friend may have moved. My colleagues and I have had some success by that procedure. Another method which has been fruitful is to search for the patient or some possible relative of the same name in the current annual telephone directory of the original city or town of residence, or in neighboring towns, or in the nearest larger cities. Not infrequently the patient or his family may have moved to a nearby street or some other suburb of the same city. When letters fail, a telephone call or a personal visit may succeed.

"In summary, then, we may hope that the value of the long follow-up in medical research will be more widely recognized, effected, and supported, particularly in establishing a base line of the natural history of various diseases for comparison with the effect of the many new medical and surgical therapeutic and preventive measures that are being constantly introduced. We can better judge the effect of treatment and prevention in coronary heart disease if we recognize, as is possible even now, the extraordinarily varied natural course of the disease through decades of time. We can better appraise the result of sympathectomy and the various hypotensive drugs if we know how hypertensive patients do without such treatment; and we can determine the ultimate effect of mitral valve surgery, which promises so much benefit to us now, if we have adequate knowledge of the course of pure mitral stenosis before its surgical treatment became a practical routine."

Examples of my personal experience in the long follow-up of cardiovascular patients are presented to illustrate the interest and importance of this technic

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PAUL DUDLEY WHITE, M.D., Boston Massachusetts certainly needs no introduction to the medical profession. He is a national authority in the field of cardiovascular diseases. Dr. White received his medical degree from Harvard University Medical School and interned at the Massachusetts General Hospital. Among other honors, his most recent attainments are the Distinguished Service Medal of the American Medical Association; Consultant to the Surgeon General, U. S. Army and Navy, and President of the International Society of Cardiology Foundation.

and some of the lessons learned thereby. Let me now present such examples:

Case 1

In 1943, I was asked to see a young man aged 22, who had been rejected for military service in the Second World War because of two findings: a heart murmur and slight hypertension. I myself did find the murmur but it was slight and dispelled by deep breathing and I considered it physiological. The blood pressure measured 160/80. I ascribed the slight systolic hypertension to the nervous state of the individual at the time. He was otherwise very fit and accustomed to vigorous exercise including mountain climbing. Happily I reassured him and he resumed a normal program of his life. A few weeks ago, a physician in charge of the U.S.A. Karakoram Expedition in the Himalaya Mountains in 1958 wrote me about this former patient of mine and sent to me an article published this winter in the *Saturday Evening Post*, telling dramatically of the first successful climb by any American team in the Himalayas of a mountain over 26,000 feet in altitude. This mountain was called Hidden Peak in the Western Himalayas in Pakistan. One of the two men who reached the top of the mountain early in July was my old patient, now aged 39. He withstood the rigors of the total climb better than all others in the team except one who was much younger. He had no cardiovascular symptoms whatsoever even in the rush to the peak the very last day of the climb. He did have frostbite but suffered no serious consequences. He still has a tendency to systolic hypertension on occasion; that is, he is a hyperreactor, but he is not a true hypertensive nor has he had the development of any heart disease of any sort.

Case 2

Early in my electrocardiographic career at the Massachusetts General Hospital I saw a healthy young man because of the finding of a quite unimportant heart murmur and noted the occurrence of an unusual electrocardiographic pattern with wide QRS waves. And yet because of his health and somewhat unusual nature of the electrocardiogram with short P-R intervals and unusual shape of the QRS waves, I hesitated to call this abnormality bundle branch block or to tell him that he had any heart disease. Reassurance seemed the wiser course. This was again a fortunate optimistic attitude to take because many years later (36, in fact) he reappeared for a checkup, having returned to the eastern seaboard. Remembering that once I had mentioned the fact that he had an electrocardiogram that looked a little odd, although not of any great significance, he came back for an electrocardiogram. On getting out his old electrocardiogram, May 24,

1917, and comparing it with his new record, May 14, 1953, it was quite obvious that he had had through all of this time a variation of the normal electrocardiogram which we ordinarily call the W-P-W syndrome. He had not had any paroxysms of tachycardia.

Case 3

In 1916 while I was medical resident at the Massachusetts General Hospital I examined a young woman who was sent to the hospital for treatment of myxedema. Her heart rate was slow, in the 40's, but she had no other particular evidence of myxedema; in fact, she gave the appearance of being somewhat thyrotoxic, having taken for some weeks a considerable daily dose of thyroid in therapy. The electrocardiogram, the first which had been taken of her, showed complete heart block with an atrial tachycardia of about 120 and a slow idioventricular rate. I have seen this patient very often in the intervening 40 years. She remains in excellent health, now in the middle 60's, with no heart symptoms at all, although she has had some apprehension and worry about her heart on occasion, best treated by reassurance and no medicines. Whether she has congenital heart block or block originating from diphtheria which she had had at the age of one and one half years is impossible to say, but at any rate it has never hurt her and proves the point about the relative unimportance of A-V block, an observation we find true also of bundle branch block, in the absence of other signs or symptoms of trouble.

Case 4

I reported in a paper entitled "Optimism in the Treatment of Cardiovascular Disease" (Emanuel Libman Anniversary Volumes October 1932, Volume 8, page 1205) 27 years ago when I spoke in Memphis, Tennessee the following case:

"In November, 1924, I was consulted by a manufacturer 48 years old, who was much worried because a serious heart murmur had been discovered at the time of a life insurance examination ten years before and constantly found since. He was in excellent health. Physical examination and roentgen examination definitely established the diagnosis of congenital patency of the ductus arteriosus. He was reassured and at annual examinations ever since he has been found in good health." Now (1959) he is 83 years old and still working hard without symptoms.

Case 5

Another man whom I discussed in that paper of so many years ago was Case 23. I wrote as follows about him:

"In Pennsylvania there is actively practicing a physician, now in his 70th year, who suffered a

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moderately severe attack of coronary thrombosis in 1921, 11 years ago. He is of long-lived ancestry. The interesting features of his case besides his longevity are his excellent health at the present time with no symptoms whatsoever, his recent marriage, and his keen interest in the progress of medicine. He has become quite an expert in electrocardiography since his attack of coronary thrombosis and goes abroad and elsewhere every year to study. I have had other physicians and surgeons as patients who have done extremely well for years after coronary thrombosis, but I have selected this example as an especially notable one for use in your optimistic practice of medicine." He continued active and in good health until he died in November 1949 at the age of 87, 28 years after his coronary thrombosis.

Case 6

This case was case No. 28 in my memorable series of 1932. I quote "One of the most interesting cases that it has been my lot ever to see is that of a young woman, now 22 years old, in perfect health but with a large three-cornered scar in the anterior chest wall made when Dr. Churchill, a surgical colleague of mine, resected a large sheet of thickened pericardium from the anterior surface of the heart, which it had gripped like a vice to prevent the proper inflow of blood. A calcified band constricting the inferior vena cava was removed at the same time. This pericardial decortication was carried out in July, 1928, after we had pondered over the case for several years and had established the preoperative diagnosis of 'Pick's disease'. The girl was transformed as by miracle through this operation from a bedridden invalid with much ascites, dependent edema, and dyspnea, to a healthy active individual who can swim and run without trouble. I saw her last a few months ago, three and one-half years after her operation and six or seven years after her invalidism had begun. She was perfectly well. The pericarditis was of unknown cause. There is no other evidence of her heart disease."

Thirty-one years after that operation she remains perfectly well, an active member of her community, with two grown children, still with a somewhat abnormal electrocardiogram and a little calcium in her pericardium but with no other objective or subjective evidence of trouble.

Case 7

This case No. 33 of my paper of 1932 which I wrote as follows: "In 1921 I obtained an electrocardiogram of a healthy athletic young woman 26 years old during a paroxysm of tachycardia, and found the mechanism to be that of auricular flutter.

She had had similar paroxysms for 12 years, ever since the age of 14. During the past 11 years she has continued perfectly well except for occasional paroxysms of tachycardia which are now becoming very infrequent. A few months ago she was one of a party to climb to an elevation of 4,700 feet and she showed no cardiac symptoms. It is now 23 years since her first paroxysm of what was probably auricular flutter. Auricular fibrillation, either in paroxysmal or permanent form, may be attended by no other evidence of heart trouble, and may carry with it a good prognosis. Sometimes it is possible to restore or to maintain normal rhythm by quinidine in such cases." Now 27 years later and 50 years since her first flutter she remains in perfect health, very vigorous, and without recent trouble from the arrhythmia.

Case 8

This was the last of the patients whom I reported in 1932 (Case 37). I stated at that time as follows: "My last case is that of a young woman who was discovered to have a slow pulse at the age of 25 years. The cause was unknown and she had no symptoms. There was no other evidence of heart disease. At the age of 26 in 1917 an electrocardiogram taken in my laboratory showed complete heart block. She has remained in excellent health ever since, having married several years ago. She plays golf often and well (incidentally she was at one time the Massachusetts State Champion) with no symptoms. Her last electrocardiogram, on May 8, 1931, showed complete heart block, exactly as had the first electrocardiogram 14 years earlier. She is now 42 years old and is known to have had a slow pulse for at least 17 years and quite likely longer. It may very well be of congenital origin." Now, in 1959, she is perfectly well at the age of 70, still with her complete heart block.

Case 9

In 1924 I saw the Dean of a Southern medical school who was regarded as having serious heart disease because of some enlargement of the heart, not adequately accounted for. He had been turned down for the Public Health Service and had been rated up for insurance. I was told the other day by Dr. de Bakey that this man had continued active and quite well until recently. He died this year at the age of 74, 35 years after he had been given a bad prognosis.

Case 10

In 1928 I saw a lady, then aged 24, with rheumatic heart disease and aortic regurgitation. She went through some stormy years with recurrent rheumatic involvement and at one time some heart block associated therewith. When I saw her last, a

few days ago at the age of 55, she was in quite good health, still with her aortic regurgitation but no important cardiac symptoms. She had had no recent paroxysms of tachycardia which used to plague her. Happily, her aortic regurgitation has not been of high degree and she has had no recent trouble. In other words, she has outgrown most of her difficulties, both physical and emotional, which evolution is very common. I have many other patients who improve with age and who are much better at 50 than they were at 40, at 60 than they were at 50, at 70 than at 60, or even at 80 than at 70.

Case 11

In April 1949, a little over ten years ago, I was consulted in Boston by a business man from South Africa who was much troubled by frequently recurrent attacks of Adams-Stokes type associated with complete A-V block, almost certainly based on coronary atherosclerotic heart disease. Shortly after I saw him, he was seen in London by Sir John Parkinson and was even sicker then than when I had examined him. At the time of a visit to South Africa a month or so ago, I examined this same man again and found him in astonishingly good health, carrying on a large business enterprise, fully active physically, playing golf twice a week, flying in his own plane, and free of Adams-Stokes attacks except for a very rare and brief one once every year or two. He has had no angina pectoris or dyspnea. His electrocardiogram taken March 23, 1959 (which I saw) showed complete A-V block with an atrial rate of 70, a ventricular rate of 28, and wide QRS waves representing bundle branch block.

Case 12

This is another striking case of heart block, almost certainly of rheumatic nature, with Adams-Stokes attacks a few years ago when I first saw him at the age of 20 in 1954. Five years later he is in excellent health, free of any heart symptoms and of syncopal attacks, teaching school actively. He is now aged 25, with both complete heart block (atrial rate 90 and ventricular rate 36) and bundle branch block. There was no evidence of diphtheria in this case but the type of heart disease is still uncertain. It may be of rare nature.

Case 13

In 1944 a district attorney came to Boston from Pennsylvania, very seriously ill with congestive heart failure secondary to malignant hypertension. He was so sick that Dr. Smithwick refused to consider him for sympathectomy. I treated his congestive failure and having cleared it persuaded Dr. Smithwick to carry out his usual thoracolumbar sympathectomy with marvelous success. When I last heard from him 15 years later in January 1959 he

reported good health, feeling very well, and still working although not so hard.

Case 14

A lady of 34 years from South America, who appeared in my office only a few days ago, was obviously convalescent from active recurrent rheumatism, superimposed on mitral stenosis, which she doubtless had had for a good many years although she had been told about it only recently at the time of an attack of so-called Asiatic flu a few months ago. While convalescent from this febrile illness, she began to show A-V block with a P-R interval at times up to 0.3 second. She had occasional fever. One of the reasons I was asked to see her was to decide about the need of operation on her mitral valve but inasmuch as she had had no cardiac symptoms prior to the illness or in fact since, it seemed quite unnecessary to operate right away. What she needed even though she was now beginning to convalesce was more adequate treatment for her rheumatic process and observation in the future as to the need of cardiac surgery. Here in retrospect was an instance of the need of long follow-up. Such a patient will no longer present herself to the doctor in the future with as little knowledge of what had been going on in the past as was true in her case.

Case 15

In 1920 I examined a healthy young woman, at that time a laboratory technician, who showed clear evidence of mitral regurgitation of rheumatic origin with a loud apical systolic murmur. Later she went to medical school in the south and became a pediatrician. She practiced actively in her profession for many years and still is very active in public health work 39 years later with the same murmur and no heart symptoms.

Case 16

Another patient of long standing came to see me in 1923, very much worried about a rheumatic mitral systolic murmur. He has weathered the years quite well since except for various episodes such as appendicitis with operation and more recently atrial fibrillation with the need of digitalis. His chief difficulty was that of neurocirculatory asthenia superimposed on his heart trouble. He gradually got rid of his symptoms and of his concern about his heart.

Case 17

In 1927 I was called to see a patient in Brookline on the third day of his attack of perfectly obvious, clearcut, acute coronary thrombosis with anterior myocardial infarction of moderate size (about grade 3 on a scale of 5). After his recovery from this acute attack, he resumed his regular business and his golf and continued at both until he was 75 years of age

since which time he has largely retired. He has had no more heart trouble whatsoever although he still shows the characteristic electrocardiographic pattern of anterior myocardial infarction 32 years after his original attack. He is now 83 years old. He suffered a little stroke a few years ago but is not badly handicapped by it.

Case 18

In 1936 I examined a man with aortitis and slight aortic regurgitation. He was symptom-free and this was an accidental discovery. His serological reaction was positive and he, therefore, was treated with bismuth and KI and ten years later with penicillin. He has continued actively at work with no change in his cardiac condition during the years since. Here then is an instance of the favorable effect of our specific therapy, both old and new, for what formerly was often a very serious condition.

Case 19

One of the most striking patients that I have ever been privileged to follow has been a young man whom I saw first in 1940 when he was a boy of 14. At that time he had slight hypertension and evidence of coarctation of the aorta in the early days of its clinical recognition. For years there was nothing specific to do for him and he remained well but finally when Dr. Gross did introduce (as did also Dr. Crafoord of Stockholm) operative surgical cure for coarctation, I sent this lad to him for advice and treatment. Since these were the early days of this type of surgery and since the boy was well Dr. Gross advised waiting. And so we waited for a few years. Finally in 1950 Dr. Gross made an appointment for the operation to be done a few months later, but in the meantime this young man developed a prolonged febrile illness which proved to be due to subacute bacterial endarteritis, undoubtedly involving the coarcted area of the aorta. After difficulty in controlling this infection by antibiotics, he was operated upon but found to have at that time a hopeless situation with a very long area of coarctation and a large aortic aneurysm below it largely secondary to the infection. It would have been necessary to replace 15 cm. or more of the aorta but at that time there was no adequate tissue for such replacement. Blood vessel banks and grafts of fabric had not yet been introduced. However, early in 1952 a length of aorta to take the place of the defect was introduced in the course of an operation which took 10½ hours. This lad's blood pressure became normal. He has been perfectly well since and has proved to be an excellent witness at hearings at

Congress in Washington for the purpose of the allocation of funds for medical research.

Case 20

Finally, I would like to cite the extreme value of the long follow-up in the critical time of assessment of the future health of President Eisenhower following his coronary thrombosis and acute myocardial infarction of September 1955. It happened that during the 1920's I collected a series of 200 cases of moderate and very severe myocardial infarction for the purpose of follow-up. In 1931 Dr. Bland and I made the first report of these 200 cases. In 1941 we made a second report which was a ten year follow-up. Finally, a year after the President's illness, we made a final report, that is, a 25 year follow-up in the fall of 1956. This follow-up was very significant in that we found that the 56 cases out of the 200 who recovered from the immediate attack of coronary thrombosis without any evidence of myocardial or coronary insufficiency after recovery and whose hearts were little if at all enlarged, had a good prognosis, 83 per cent surviving five years and 56 per cent surviving ten years. Since the President belonged in this category we were able to say that our prognosis was reasonably favorable as it has since proved to be. Thus, our prognosis was not based on guesswork or political expediency. Rehabilitation of many other cases of coronary thrombosis has been stimulated by this follow-up.

It is, however, quite evident that the actual prognosis of coronary thrombosis at its very onset was not presented in this follow-up of my own 200 cases whom I saw as a consultant often not until several days, weeks, or even months had passed, although many I did see very early. To correct this difficulty, inasmuch as there has been no adequate series of cases published that had been followed up from the very onset of the attack, a research has recently been made by all the physicians of the six northeastern counties of North Dakota under the aegis of the Public Health Service and the local Heart Association whereby every new case of coronary thrombosis was registered. The results of this study will be published later but the immediate mortality was much higher than in my series. This is to be expected since a good many cases die very quickly and some even before they are seen by any doctor.

Here then are a score of examples of cases normal, congenital, rheumatic, syphilitic, hypertensive, and coronary, including two cases of Adams-Stokes syndrome, showing the value of the long follow-up from the experience of one practitioner. They can be duplicated over and over again. They point to important lessons, chief of which may be the need of an optimistic outlook in prognosis partly because

of the rapid development of new measures of diagnosis and treatment and partly because the optimism itself has a favorable effect on the patient and on his willingness to cooperate with his medical advisors. This is, of course, merely part and parcel of psychosomatic therapy, which should always be a component of overall treatment.

It is obvious that in many fields in medicine we have still a lot to learn about prognosis and the effect of treatment with adequate controls by the horizontal research of individuals, of groups of patients, and of populations. This has been very evident in the field of cardiovascular disease, but there is still a great deal of opportunity and obligation in this long follow-up for those of us in private practice or indeed in other fields of medicine too, such as public health, research, and teaching.

Conclusion

In conclusion, I would like simply to mention briefly some of the interesting and very important international epidemiological researches (and national, too) now going on and planned for the future with emphasis on the long follow-up of groups and populations.

(a) In 1954 a report of 100 cases was published by Gertler and myself of a study carried out by a group of investigators at the Massachusetts General Hospital of myocardial infarction in young adults under the age of 40 years with a comparable series of control cases. These patients and the controls are now being followed up for further report. It is already evident that a number of the control cases were also candidates inasmuch as they have developed coronary heart disease in this interval. It will be interesting in our analysis to know whether these new cases of coronary thrombosis resemble those that we had already studied. We are anxious, of course, to obtain as many details as possible for the selec-

tion and protection of the candidate for early coronary heart disease.

(b) During the past few years we have compared groups of South Italian males, 40 to 70 years of age, living in and around Naples with other South Italians who have themselves emigrated to Boston in their childhood or who are of the second generation. This study has demonstrated quite clearly that coronary heart disease is several times more common in the Boston South Italians than in the Neapolitan South Italians. Also, the study demonstrated the higher fat content of the diet and of the blood. What other factors beside diet may play a role is still uncertain.

(c) A similar comparison was carried out of the Southern Japanese living in and around Fukuoka with the Southern Japanese who had gone in their youth to Hawaii to work in the plantations there. Again the fat in the diet, the fat in the blood, and coronary heart disease were higher in amount in the Southern Japanese in Honolulu than in those in Fukuoka.

(d) The opportunities for this kind of epidemiological research on populations in Africa was very evident to me on my recent visit to Africa—east, south, and west. There a comparison of the whites, blacks, and browns should yield much information during the next decade or two with respect to a variety of problems, in particular that of atherosclerosis. There is such rich opportunity for example at Dr. Schweitzer's Hospital for such a study. A good deal of this research is underway in South Africa at Cape Town under the wing of Drs. John Brock and Bronte-Stewart.

Thus, there is much for us all to do with the long follow-up both in private and in public health. Let me end with an appropriate quotation from Shakespeare:

"Our remedies oft in ourselves do lie
Which we ascribe to Heaven"

264 Beacon Street

AMERICAN CANCER SOCIETY FELLOWSHIPS

AWARD OF FOUR clinical fellowships to young doctors in Georgia was announced recently by the American Cancer Society.

Clinical fellowships went to three doctors at Emory University. They are Dr. William A. Nelson, specializing in surgery; Dr. Robert B. Quattlebaum, radiology, and Dr. Duane T. DeVore, oral pathology. The other fellowship went to Dr. Pyrrha G. Grodman of St. Joseph's

Infirmery, Atlanta, whose specialty is pathology. Each fellow received \$3,600 for one-year of training.

In announcing the grants, Dr. A. H. Letton of Atlanta, professional education chairman of the Cancer Society's Georgia Division, said they were included in a total of \$704,800 awarded by the Society for the training of young physicians throughout the nation.

SOME APPROACHES TO CLINICAL BLOOD COAGULATION IN CHILDREN

The evolution of the theories of coagulation is discussed and our present day laboratory diagnostic aids are evaluated.

Preston D. Ellington, M.D., Augusta

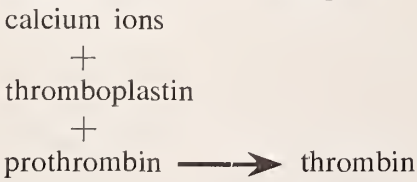
WITHOUT QUESTION THE INFINITE number of papers to be found in our medical libraries today stand as mute evidence of the intrigue, the mystery, and the continuing complexity of hemostasis. I am sure that it would be impossible at the present time or probably ever to present a unified concept that would be acceptable by everyone concerned with this problem.

The control of hemostasis is essentially invested in four basic elementary mechanisms:

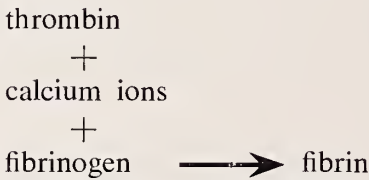
- (1) The vascular system
- (2) The platelets
- (3) The coagulation mechanism
- (4) The fibrinolytic system

A severe spontaneous hemorrhagic problem usually indicates defects involving more than one of these basic mechanisms and conversely, hemorrhage may not occur at all in instances in which only one elementary mechanism is defective providing that all the other elements are normal.

Since a presentation of all these mechanisms would be beyond the scope of this paper we will confine the discussion to the coagulation mechanism. Morawitz in 1904 presented a theory that blood coagulation probably occurred in two successive enzymatic phases. Even at the time of this presentation it was realized that this theory was inadequate.

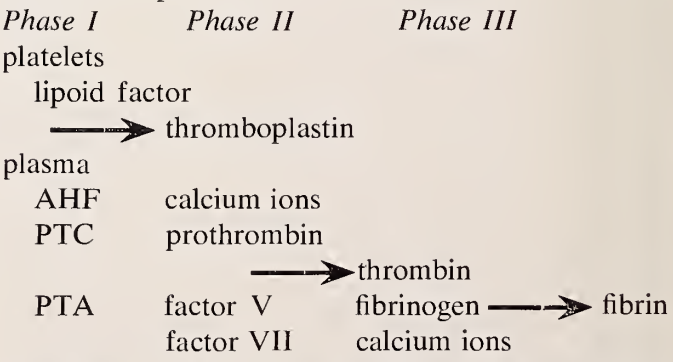


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It did satisfactorily explain the absence of intravascular clotting in the normal person and the occurrence of clotting of blood in the veins of the dead, depending on the absence or presence of an enzymatic factor called thromboplastin which was considered to be derived from destroyed tissue cells and possibly from platelets. According to this theory the end result was the formation of an insoluble protein, fibrin, which is not present in the normal circulation. This conversion of fibrinogen to fibrin required reaction with ionizable calcium and a factor, thrombin, which was not present per se in the circulation but was formed from a precursor substance, prothrombin.

Prothrombin itself was converted to thrombin in the presence of ionizable calcium and the tissue factor thromboplastin.



As early as 1908 Nolf recognized the probability of additional sources of thrombin and then in 1912

Collingwood and others postulated another most important phase in the coagulation mechanism, that of thromboplastin formation.

One must realize that a process that was once thought to be relatively simple is now known to be very complex and to involve not only many factors necessary for the coagulation of blood but also the infinite number of reactions that must occur.

The differential concentrations of these factors, the rates of consumption, and the presence of other substances or factors tend to interfere with the coagulation process.

Again one must realize that it would be impossible to present a simple review of a complex process that is universally acceptable and although this is a hypothetical trichotomy to be discussed it does not generally differ with substantiated facts.

This trichotomy is divided into these three phases:

Phase I: Thromboplastin formation

Phase II: Thrombin formation

Phase III: Fibrin formation

Phase I has two basic factions, a cellular faction comprised of platelets and a non-cellular faction composed of plasma factors. The agglutination and lysis of platelets in the area of a loss of vascular integrity probably represents the initiating action of blood coagulation. Upon lysis of platelets many essential substances are either formed or released, among them a lipid factor which reacts with plasma factors to form thromboplastin.

The presence of adequate amounts of anti-hemophilic factor (AHF) and lipid factor (LF) is indispensable for the subsequent formation of thromboplastin. The activity of other plasma factors in Phase I is not clearly understood at this moment. Plasma thromboplastin component (PTC) factor and plasma thromboplastin antecedent (PTA) factor may act as catalysts for the reaction between the lipid substance from platelets and AHF of plasma.

Formation of Thromboplastin

The formation of thromboplastin undoubtedly passes through intermediate phases before the active substance is available for reactions. Deficiencies involving platelet activity or the plasma factors in Phase I, or the presence of substances which tend to inhibit thromboplastin formation or interfere with the activity of formed thromboplastin results in abnormalities of the coagulation mechanism and is usually identifiable by prolongation of the clotting time, inadequate thromboplastin generation in the plasma, and excessive prothrombin activity in the serum.

The reaction of ionizable calcium and thromboplastin alone is inadequate for the conversion of sufficient amounts of prothrombin to thrombin and requires the presence of other factors referred to as

the labile factor (Factor V) and the stable factor (Factor VII) in Phase II.

The exact mechanism of the various reactions and interreactions in Phase II is not fully known but may be a stoichiometric reaction with the formation of a complex which reacts with prothrombin to form thrombin.

Deficiencies of these factors or the presence of anticoagulants or other agents which tend to interfere with these reactions results in coagulation problems and is reflected in the prolongation of the clotting time and an abnormal plasma prothrombin activity.

In Phase III the conversion of fibrinogen to fibrin through intermediate phases is considered to be one of internal molecular rearrangement in the presence of thrombin and ionizable calcium ions. Deficiencies of fibrinogen or the presence of certain anticoagulants will result in varying degrees of abnormalities of coagulation. The role of the calcium ion throughout the coagulation mechanism is not fully known but it is doubtful that a severe hemorrhagic problem is attributable to calcium deficiencies alone.

Perhaps in no other disease entity does the adequate history and physical examination play such an important role as it does in hemorrhagic conditions due to defects in the mechanisms of hemostasis. When confronted with a hemorrhagic problem one must first establish that this represents a primary problem and is not secondary to a general systemic disease or condition, such as leukemia. This is often apparent with an adequate evaluation of the history and physical examination. There are certain usually readily available laboratory procedures that are indispensable in any hemorrhagic problem:

1. Platelet count
2. Hess test
3. Coagulation time (Lee White)
4. Bleeding time (Ivy)
5. Clot retraction test
6. Plasma prothrombin time
7. Serum prothrombin activity
8. Fibrinogen determination
9. Lysis of the clot observation.

In plasma coagulation defects one or more of the following elementary mechanisms may be involved:

- (a) Deficiency of one or more of the plasma factors
- (b) Interference with the activity of one or more of the plasma factors by circulating anticoagulants
- (c) Excessive activity of the fibrinolytic system.

One must ascertain which of these mechanisms is responsible for the coagulation defect before a definitive diagnosis can be established. The addition of

normal blood or plasma does not alter appreciably the coagulation time of blood containing abnormal circulating anticoagulants but does in defects of plasma factors. Observation for complete lysis of the clot within a short time (two hours or less) establishes the presence of excessive fibrinolytic activity.

Total circulating platelet counts are often unreliable and a correlation with the peripheral blood film platelet population as to apparent adequacy of platelets should always be made. The Hess test or tourniquet test is usually a reliable indication of vascular integrity or adequate platelet function. There is little place in a hematological profile for a clotting time determination using capillary tube techniques due to its unreliability even as a screening test. The Lee White procedure using venous blood under exacting conditions is the most reliable technic usually available and significant prolongation of the clotting time usually indicates a defect in the plasma coagulation mechanism. A normal Lee White clotting time does not in itself rule out plasma factor defects, however severe.

The bleeding time, using the Ivy technic, is usually prolonged in hemorrhagic or purpuric disorder involving the vascular system or platelets although it may be occasionally prolonged in plasma coagulation defects. Clot retraction is an indicator of platelet function and fibrinogen activity. The plasma prothrombin time as routinely performed in most labora-

tories measures also the adequacy of the labile and stable factors. When normal blood clots approximately 80 per cent or more of the plasma prothrombin is utilized such that the serum prothrombin activity normally is low. In any significant defects in the coagulation mechanism in which there is a deficiency of the plasma factors in Phase I, interference with the formation of thromboplastin, inhibition of the activity of formed thromboplastin or severe deficiencies of Factor V or Factor VII there is an increased amount of serum prothrombin resulting in excessive serum prothrombin activity. Defects in Phase III represent excess antithrombin activity or fibrinogen deficiencies. In the complete absence of fibrinogen blood does not clot. Hypofibrinogenemia represents fibrinogen concentrations of less than 80-100 mgm. per cent which may be inadequate to maintain normal hemostosis.

The definitive diagnosis of a coagulation mechanism defect is of more than academic interest in that adequate management of the acute hemorrhagic episode with some understanding of the underlying pathological process and early restoration of normal hemostasis depends upon an early and accurate diagnosis. Recognition of the complexity of the coagulation process which represents only one of the basic mechanisms in hemostasis substantiates the ready realization that only an adequate clinical evaluation of the patient, complimented with exacting laboratory procedures, and frequently time and observation, will permit a definitive diagnosis.

1727 Central Avenue

WHERE DOCTORS ARE DISCOURAGED

A FEW MONTHS ago Harper's magazine published an article on Britain's socialized medicine system. The author had much praise for it, and cited the fact that when he suffered a chipped elbow he was given free care.

This brought a letter from an American doctor, which Harper's published in its July issue. This doctor found that statements in the preceding article "sound like the ecstasies of a confirmed freeloader who has discovered a saloon which still offers the old-time free lunch." Then he went on: "There is a widening gap between the quality of medicine as it is practiced in the United States and in Great Britain. According to Dr. Alistair Luton, an English physician now in the United States under a Ford Foundation grant, this is a typical English doctor's day:

"50 patients before lunch

"50 patients after lunch

"20 or 30 house calls daily.

"Should we wonder that the English doctor is discouraged and unable to keep up with the march of medicine?"

Deterioration of standards and services is always a result of socialism—socialized medicine included. It could happen here, just as it has happened in England. And anyone who thinks that the socialized medicine issue is dead so far as the U. S. is concerned had better think again. A current proposal, for instance, would provide government-paid medical and hospital care to people drawing Social Security payments. Once that precedent was established, it would be just a matter of time before other groups demanded and received similar treatment. As the old Chinese proverb has it, the longest journey begins with a single step.

—Rome News-Tribune

ILEOCECAL HEMORRHAGE

This is the first reported series in the literature with major gastrointestinal hemorrhage due to ileocecal prolapse.

Duncan Shepard, M.D., *Atlanta*

THERE IS STILL controversy over the anatomy of the ileocecal valve due to variations in the normal valve and the difference between its appearance during life and in the cadaver. No agreement exists about whether an ileocecal sphincter exists or whether competency of the valve is due to the two lips being pushed together by intracecal pressure.^{1,5,6,11,18,21,24,27}

Pathology and Clinical Picture

The benign and malignant lesions inherent to the colon are found in the ileocecal valve as well as inflammatory changes whose etiology is difficult to determine. Edema of the valve may be idiopathic or secondary to prolapse of the ileal mucosa or to intermittent relenting intussusception.^{3,4,14,17,21,22} Strombeck²³ first pointed out the association of edema of the valve with regional enteritis and this was later confirmed by Golden¹² and others.¹⁷

True lipoma of the ileocecal valve has been described and has a limiting capsule^{9,25} as well as lipomatous infiltration which is also called lipomatous hypertrophy of the valve.^{9,10} Although these conditions do not produce symptoms as a rule,⁷ they have a characteristic radiologic appearance, consisting of a radiolucent shadow which is sharply demarcated from the surrounding tissues; this is especially true of lipoma of the valve.¹⁷ Other benign tumors of the ileocecal valve have been reported.¹⁶

Although ileocecal prolapse is an uncommon lesion, it has been described, more frequently in the past few years; Perkel and Troast²⁰ discovered 19 instances in 1,100 routine barium enemas, although they were making no particular search for this condition. It is most frequently seen on compression films of the barium filled cecum. No pathognomonic signs have been described and the entity is usually discovered on a barium enema which is done searching for a cause of abdominal discomfort. Radio-

logically, it appears as a round or ovoid space occupying defect in the cecal shadow resembling a large polyp of the cecum or ileocecal valve (Figure 1a and 1b). In profile it may appear as an epsilon shaped defect^{8,22} and when seen *en face*, it resembles a doughnut or rosette, at times demonstrating creases produced by the edematous prolapsed mucosa.^{8,22} (Figure 2) Lasser and Rigler¹⁷ have shown that prolapse of the valve produces a defect which varies in size and shape from examination to examination, while malignancies of the area are rather constant in outline; Beranbaum and Subbarao² offer confirmatory findings. It is usually difficult and often impossible to distinguish between benign lesions of the ileocecal valve and carcinoma arising on the valve or in the cecum.^{2,9,15,17,22} (Figure 3) For example, Le Brun¹⁹ reported 13 cases of carcinoid tumor of the ileocecal valve in patients who had recurrent gastrointestinal disturbances lasting more than a year. These patients on examination showed no anemia and by barium enema showed a contracted cecum with a smooth round filling defect of the valve indistinguishable from prolapse of the ileal mucosa.

Lasser and Rigler¹⁷ studied 18 cases of ileocecal

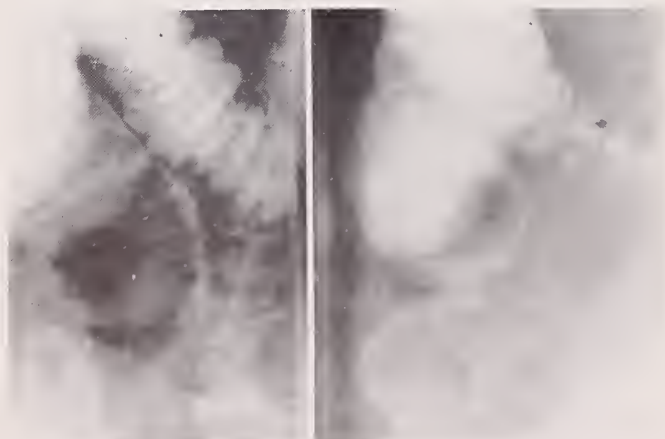


Figure 1a: Ileocecal prolapse. Figure 1b: Ileocecal prolapse.

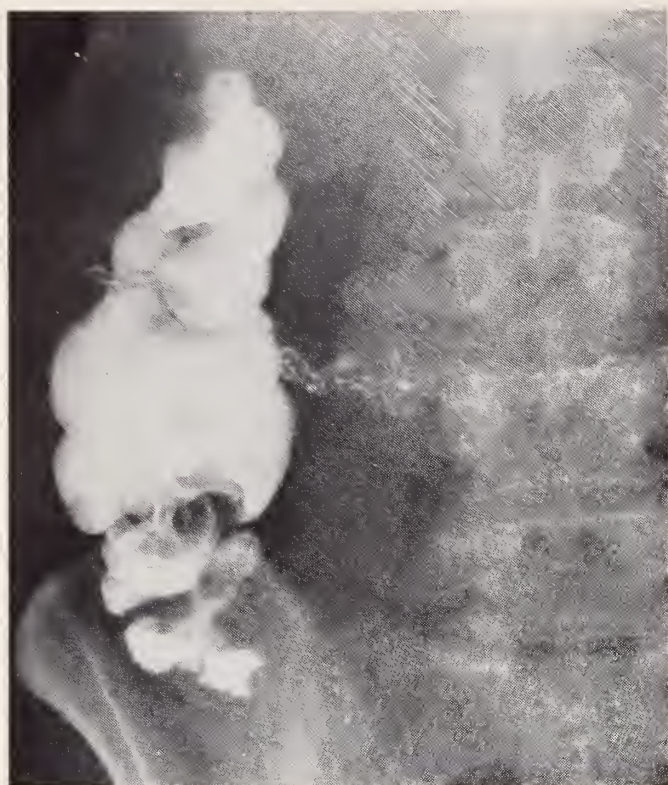


Figure 2: Ileocecal prolapse, en face demonstrating rosette phenomenon.

prolapse and found that in 16 there was abdominal pain and nine were suspected of having chronic gallbladder disease; three additional patients had the symptoms of chronic gallbladder disease, although they had already had cholecystectomy. Twelve of the patients were female and only one was below 45 years of age, while seven of the patients had point tenderness over the ileocecal valve on physical examination.

Sauer, Hodgson, Mayne, and Judd²² have shown that it is impossible to be certain of the histologic diagnosis of lesions in the ileocecal area by means of history, physical examination, and barium enema.

Diagnostic laparotomy is indicated whenever there is a cecal defect which is atypical of prolapsed ileocecal valve or when the defect is accompanied by blood in the stool, anemia or a palpable mass.¹⁵

Case Reports

Case 1. (A.C.S.) A white male, age 34, had an upper respiratory infection two weeks prior to hospitalization. Elsewhere he was given eight tablets of an antibiotic orally over a two day period. Five days prior to admission, he had three watery stools followed by melena; the next day, after passing a large tarry stool, the patient fainted and was hospitalized.

Approximately four weeks prior to admission he had had an annual physical examination elsewhere, at which time the hemoglobin measured 16 gm. per



Figure 3: Ileocecal prolapse. Same patient shown in Figure 2 x-rayed 48 hours later showing irregular filling defect of cecum characteristic of carcinoma of cecum.

100 ml., and examination of the colon by means of a barium enema was negative. On questioning, the patient stated that he had had vague, intermittent discomfort in the right lower abdominal quadrant for approximately one year, but there had been no change in bowel habit prior to the present illness.

On admission to the hospital the hemoglobin was 11.5 gm. per 100 ml. and eight hours later it was 9.5 gm. per 100 ml., the packed cell volume was 28.5 per 100 ml. and the red cell count 2,910,000, despite the administration of 1,000 cc. of whole blood in the interim. White and differential blood counts were normal. Platelets appeared in normal number on the blood smear. The bleeding time (Duke's) was two minutes 15 seconds and the clotting time (Lee White) was 15 minutes.

Physical examination revealed a pale, perspiring, young, white male, complaining of crampy, lower abdominal pain. Peristaltic sounds were hyperactive but there was no abdominal tenderness, spasm, nor mass. Rectal examination was normal except for tarry material on the examining finger. The source of the bleeding was not apparent but pseudomembranous enterocolitis was thought to be a possible cause, because of the preceding antibiotic therapy. Sigmoidoscopic examination was performed up to 25 cm. and no abnormality was seen. A smear and culture taken for staphylococci were negative. Examination of the colon by means of a barium enema was normal; the appendix and terminal ileum were visualized. Examination of the upper gastrointestinal tract by means of a barium meal was normal. Melena

continued and despite the administration of an additional 1,000 cc. of whole blood, the hemoglobin was 9.4 gm. per 100 ml. Due to the continued bleeding it was felt that abdominal exploration was indicated. The patient was given an additional 1,000 cc. of whole blood before surgery.

Diagnostic laparotomy was performed. The entire colon was filled with blood but none was seen in the stomach, duodenum, nor small intestine. A soft compressible lesion was felt at the ileocecal valve and was thought to be a sessile polyp. Cecotomy was done and prolapse of the ileal mucosa through the ileocecal valve was seen. There was no gross ulceration but the mucosa was intensely injected and was thought to be the source of melena. A right colon resection was done and gastrointestinal continuity was reestablished by means of an end-to-end ileocolostomy.

Gross pathological examination revealed the resected specimen to consist of a segment of terminal ileum and the proximal half of the colon with attached appendix. At the ileocecal valve there was prolapse of the ileal mucosa into the cecum. Microscopic examination of sections of the ileocecal valve at the point of prolapse showed edema, a moderate, acute, inflammatory infiltration, and severe congestion with interstitial hemorrhage of the prolapsed mucosa and submucosa. There was loss of the overlying epithelium which was replaced by hemorrhage. The submucosal hemorrhage extended into the muscularis at the point of juncture between overlying cecal and ileal mucosa (Figure 4).

Convalescence was uneventful and at the last examination ten months following surgery, the patient had had no further melena and was asymptomatic.

Case 2. (A.R.McD.), a white male, age 79, with severe arteriosclerosis and arteriosclerotic heart disease with intermittent heart failure and a past history of myocardial infarction with uneventful recovery. The patient had been on a regimen of oral diuretics and digitalis. He had had no abdominal symptoms,

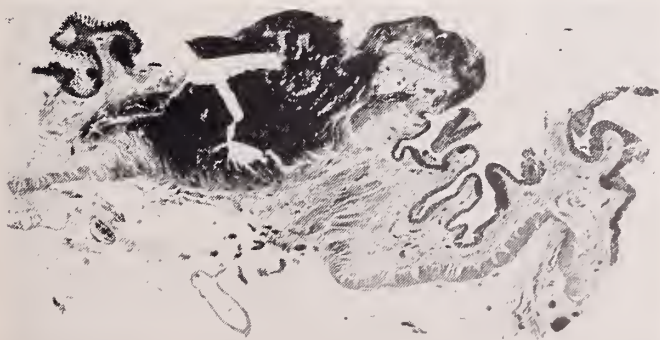


Figure 4: Ileocecal prolapse. Low power photomicrograph of prolapsed ileal mucosa. The dark area represents hemorrhage. On the left is ileal mucosa and on the right is colonic mucosa. The mucosa is absent over the area of hemorrhage.

indigestion nor change in bowel habit. In the 24 hours before hospitalization he had been nauseated and vomited on three occasions but had vomited no blood. There was onset of painless melena in large amounts 24 hours prior to my examination. He was hospitalized at the onset of melena and received transfusions of whole blood and appeared to have stopped bleeding. His hemoglobin eight hours before examination was 10.1 gm. per 100 ml. Two hours prior to my examination there was recurrence of massive melena with large clots and the passage of bright red blood per rectum. His blood pressure, which had been 190-200 ml. of mercury systolic prior to his present illness, had remained in the range of 100-110 ml. of mercury systolic since the onset of his illness.

On physical examination the patient was pale but not perspiring. His abdomen was not distended and there was no tenderness, mass, nor spasm. There was a McBurney scar (appendectomy) and large, bilateral, indirect, inguinal herniae. Peristaltic sounds were hyperactive. Digital rectal examination was normal except for tarry material on the examining finger.

The diagnosis was massive melena of undetermined origin. As the patient appeared to be exsanguinating, was elderly and in poor condition, it was thought unwise to subject him to extensive diagnostic radiologic studies.

A diagnostic laparotomy was done after the administration of whole blood transfusions. The stomach, duodenum, and small bowel contained no blood, but the entire colon was filled with old blood. No intrinsic lesion could be seen nor felt in the bowel. The possibility of a prolapse of the ileal mucosa with hemorrhage was considered and accordingly, a cecotomy was done. The ileocecal valve was found to be prolapsed into the cecum and the mucosa was edematous and hyperemic and thought to be the site of bleeding. Accordingly, a right colectomy was done removing 20 cm. of the terminal ileum, the cecum, and one half of the ascending colon. An end-to-end ileocolostomy was done; a tube gastrostomy was performed; and the abdomen closed. The patient's convalescence was uneventful.

Gross and microscopic examinations of the resected specimen of bowel showed prolapse of the ileocecal mucosa through the ileocecal valve. There was a prominent degree of melanosis coli. In addition, there was severe congestion of the superficial capillaries of the mucosa. No gross ulceration was demonstrated.

On last examination five months postoperatively, the patient's blood count was normal and he had had no further melena.

Case 3. (T.C.F.) A white female, age 57, had

ILEOCECAL HEMORRHAGE / Shepard

known essential hypertension and had been treated with Serpasil®. She had had episodes of crampy, lower abdominal pain for the past 12 months, but no change in bowel habit. She had been in the habit of eating an apple at bedtime for many years, but she had been forced to discontinue this as the apple almost regularly initiated the crampy, lower abdominal pain, starting in the right lower quadrant and radiating across to the left lower abdominal quadrant. Although the discomfort was not incapacitating or very severe, it was most prominent in the area of McBurney's point. In the past she had been anemic and had been on oral iron therapy for the past five months. Two weeks prior to my examination, there was onset of weakness, ease of fatigue, and anorexia, although there was no nausea, vomiting, nor upper abdominal discomfort. The patient discontinued her oral iron therapy two days prior to hospitalization and since discontinuing the iron, she had noticed that her stools were brown but were mixed with a great deal of bright red blood. This bleeding had been present with each stool.

She had had total abdominal hysterectomy followed by X-ray therapy for carcinoma of the fundus to the uterus in 1936; she had had no further difficulty relative to her pelvis.

On physical examination there was marked pallor of the skin and mucous membranes. Blood pressure measured 148/80 mm. of mercury. Examination of the abdomen showed no distention, tenderness, nor mass. There was a wide mid-line suprapubic scar. Hemoglobin measured 7.8 gm. 100 ml. and the packed cell volume was 26 per 100 ml.

The patient was given 500 cc. of whole blood by transfusion and the following day her hemoglobin was 9.8 gm. per 100 ml. and the packed cell volume was 30 per 100 ml. Sigmoidoscopic examination revealed no intrinsic lesion of the rectum or colon to a level of 15 cm.; at this point there was an acute angulation of the colon and the scope could not be passed to a higher level. Old black blood was seen trickling down from above. X-ray examination of the colon by means of a barium enema showed an ovoid space occupying radiolucent shadow at the ileocecal valve interpreted as lipomatous infiltration of the ileocecal valve. In addition, there was diverticulosis of the sigmoid colon.

The ileocecal lesion was thought to be the source of the patient's melena. Accordingly, she was given 1,000 cc. of whole blood by transfusion and her bowel was prepared with oral neomycin. Laparotomy was done under general anesthesia. The appendix, uterus, and adnexae were missing and there



Figure 5: Case No. 3. Cecotomy showing lipomatous infiltration of ileocecal valve with prolapse; this was the source of major melena. Note the resemblance to the uterine cervix grossly.

was no evidence of recurrence nor metastasis from her former carcinoma of the fundus of the uterus. Exploration of the stomach, duodenum, and small bowel was entirely normal. No old blood was seen in the small bowel nor in the colon; the patient's melena had stopped 24 hours prior to laparotomy. On palpation of the cecum, there was a soft palpable mass in the area of the ileocecal valve. Cecotomy was done and prolapse of the ileal mucosa was seen. The mucosa was a lighter yellow than normal, suggesting a lipomatous infiltration or a lipoma of the ileocecal valve, and the solitary nodules of the prolapsed mucosa were more prominent than normal (Figure 5). A limited right colectomy was done removing 15 cm. of the terminal ileum, the cecum, and one half of the ascending colon, and an end-to-end ileocolostomy was done.

Microscopic sections of the ileocecal valve showed lipomatous infiltration of the valve without limiting capsule. Lymph nodes of the area showed reactive hyperplasia.

The patient's convalescence was uneventful and on last examination four months following surgery, she had had no further melena nor crampy abdominal pain.

Discussion

There is no typical clinical picture of prolapse of the ileocecal valve, lipoma, or lipomatous infiltration of the valve.¹⁷ Despite the many articles in the radiologic literature describing differentiation of benign from malignant lesions of the ileocecal valve, the work of Sauer, Hodgson, Mayne, and Judd²² has shown rather convincingly that differentiation is impossible short of diagnostic laparotomy. This is confirmed by Le Brun's report of carcinoid tumors of the valve indistinguishable from benign lesions.¹⁹

A review of the literature reveals no report of a

patient with gross hemorrhage from prolapse of the ileocecal mucosa through the ileocecal valve.

Case 1 exhibited melena of life-endangering magnitude which continued despite blood transfusions. At laparotomy there was gross evidence of the blood being confined to the colon and the only other gross abnormality was the soft, palpable cecal mass. At cecotomy there was gross evidence that the prolapsed ileocecal mucosa was the source of hemorrhage, and this was confirmed by microscopic examination.

Case 2 exhibited exsanguinating melena and the only abnormality found at operation was prolapse of the ileal mucosa through the ileocecal valve. There was marked congestion of the prolapsed mucosa but no microscopic evidence of ulceration. This patient has remained asymptomatic following limited right colectomy, and the melena probably came from the prolapsed and congested ileocecal valve.

Case 3 had had bouts of intermittent, colicky, right lower quadrant, abdominal pain radiating to the left lower quadrant over a period of 12 months prior to surgery. This patient also presented exsanguinating melena. On diagnostic laparotomy there was prolapse of the ileal mucosa and lipomatous infiltration of the ileocecal valve with marked congestion.

Prolapse of the ileal mucosa must be considered as a possible cause of melena, at times of life-endangering magnitude; the bleeding is often painless but may be preceded by intermittent, crampy, lower abdominal pain, more particularly in the right lower abdominal quadrant as is evidenced in two of the cases here reported.

Summary

Three cases of prolapse of the ileal mucosa through the ileocecal valve are reported. One of these was associated with lipomatous infiltration of the ileocecal valve. All of them were accompanied by exsanguinating melena and two of the cases had preceding attacks of mild, crampy, lower abdominal pain. This lesion must be considered as a possible cause for melena. A review of the pertinent literature is included.

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ANESTHESIA FOR OTOLARYNGOLOGY IN INFANTS AND CHILDREN

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THE POSTULATION THAT anesthesia for otolaryngologic procedures presents no problems is a gross misconception. The frequent performance of these procedures and the brevity of most of them, coupled with the fact that they are often performed in the doctor's office with open drop and insufflation ether has schooled the physician to accept and treat the numerous emergencies that arise.

If the physician's experience and training is limited to the above method of anesthetic management, it is not recommended that he attempt to employ the more complicated, modern anesthetic technics. However, if a skilled, capable anesthesiologist is available, then the patient should be given the benefits of preanesthetic medication and endotracheal anesthesia, for the safety and comfort thereby provided commences with induction of anesthesia and extends through to the recovery period. At the same time, the technic provides better conditions for the surgeon.

Alleged technical difficulties of endotracheal anesthesia evaporate when the anesthesia is managed by a person trained in the technic. As in the practice of all good medicine, meticulous attention to details produces the best results, originating with the preanesthetic evaluation and preparation of the patient and carrying through the anesthetic management and postanesthetic care.

Preanesthetic Evaluation and Preparation

Even though in most instances the infant or child scheduled for an otolaryngologic operation is comparatively healthy, a thorough preanesthetic evaluation of the patient is a requisite of safe anesthesia. The anesthesiologist reads the history, physical examination, laboratory results, and treatment recorded on the hospital chart. The existence of any condition which might influence the management of the anesthesia is explored further when the anesthesiologist makes his preanesthetic visit to the patient. Prepara-

The comfort and safety afforded by the endotracheal technic make it the preferable anesthetic procedure.

tory consultations with the pediatrician or general practitioner and with the surgeon provide further pertinent information regarding the condition of the patient, proposed operation, and its probable length, blood requirements, posturing of the patient, and other factors essential for the safety of the patient and for the facility of the surgeon.

Of particular concern in the evaluation of an infant or child scheduled for otolaryngologic operation are those conditions which may interfere with the patency of the airway. Included in this category are choanal atresia, laryngomalacia, laryngeal webs, papilloma, and paralysis of the vocal cords, vascular rings, stenosis of the bronchus, or foreign bodies in the bronchus. As well, those conditions which may interfere with pulmonary ventilation should be given strict attention in the preanesthetic study. In this class are poliomyelitis, amyotonia congenita, myasthenia gravis, absent abdominal musculature (prune belly), atelectasis, bronchiectasis, and pneumothorax. A patient with any of the obstructive lesions above mentioned will receive reduced sedative premedication and the induction of anesthesia will be delayed until the otolaryngologist is in the operating room prepared to do an emergency tracheostomy should it be deemed necessary. A minimum of anesthetic agent is ordinarily administered to a patient who has some respiratory impairment, for postoperatively it is essential that the integrity of respiration return to normal as soon as possible. If the patient has myasthenia gravis, the anesthesiologist will not select ether or d-tubocurarine as anesthetic agents because this combination may produce a prolonged respiratory paralysis.

Also requiring a critical assessment are patients

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with congenital heart disease or acquired heart disease such as rheumatic fever, since any affliction that impairs the cardiovascular system is of vital concern to the anesthesiologist. Of special significance is the existence of a chronic anemia, which causes an enlarged, flabby heart with fatty degeneration. Such a heart is brought to a standstill easily by a brief period of anoxia or by overdosage of anesthetic agent.

Having completed the preanesthetic evaluation of the patient, the anesthesiologist orders the preanesthetic medication and then determines the anesthetic agent and technic most suitable for the particular patient and operation.

Anesthetic Management

The choice of anesthetic agent for tonsillectomy is generally fluothane and nitrous oxide, or cyclopropane, using the endotracheal technic.

For rhinoplasty or mastoidectomy where epinephrine is used for vasoconstriction, the anesthesiologist employs intravenous thiobarbiturate, muscle relaxant, and nitrous oxide, using endotracheal technic.

For bronchography, intravenous thiobarbiturate and succinylcholine chloride are given, with oxygen insufflated down the open arm of the bronchoscope. In older children, a chest cuirass can be used, combined with intravenous thiobarbiturate and a muscle relaxant. This particular method is also useful for removal of papilloma of the vocal cords, although if a cuirass is not available, in some instances, a fine endotracheal catheter can be inserted through the glottis and nitrous oxide and oxygen tracheal insufflation carried out through this catheter. The patient can be made apneic with thiobarbiturate and muscle relaxant, and intermittent compression of the sternum provides the artificial respiration.

In spite of criticism of endotracheal anesthesiology in infants and children, there has been a marked increase in our employment of this technic during the last 20 years. At times we have reverted to the ether insufflation technic, but the ensuing complications have firmly convinced us that if endotracheal intubation is employed by an anesthesiologist thoroughly

trained in its application to infants and children, the complications are far fewer than with the older method. It is evident from these statements that we feel the advantages of endotracheal technic far outweigh the disadvantages.

Advantages of Endotracheal Anesthesia

1. More sedative preanesthetic medication can be given, thereby producing a comfortable and cooperative patient.
2. A less toxic variety of anesthetic agents can be employed.
3. Lighter stages of anesthesia can be employed during the operation.
4. Dead space is reduced.
5. Mouth gag can be opened widely to facilitate surgery.
6. A patent airway can be maintained, permitting the free entrance and exit of gases into and out of the lungs.
7. Pulmonary ventilation can be controlled.
8. The anesthesiologist is removed from the immediate operative field.
9. Respiratory tract secretions can be removed by means of a polyethylene catheter, which is inserted through a suction port in the angle piece of the endotracheal tube.
10. The postanesthetic recovery period is shorter, and in most instances, there is little nausea and vomiting.

Disadvantages of Endotracheal Anesthesia

1. The tube may become obstructed by inspissated blood and secretion, by kinking, by the patient biting the lumen of the tube when in light anesthesia, or in the case of long bevelled tubes the distal opening may be blocked by being pushed against the wall of the trachea or bronchus.
2. If the angle piece is too small or too large, it may separate from the endotracheal tube.
3. If the laryngoscope is not inserted carefully, teeth may be chipped or knocked out, or the lip may be caught between the teeth and the laryngoscope blade, cutting the lip.

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4. Endobronchial anesthesia may inadvertently result if too long a tube is used; or the tube may slip out of the glottis when the glottis descends on inspiration, if too short a tube is used.

5. If the diameter of the tube is too large, trauma may result; or if the diameter is too small, partial obstruction to respiration may result by preventing adequate pulmonary ventilation.

6. Lubricants on the tube may cause irritation.

7. Rupture of the alveolar walls (emphysema), pneumothorax, or mediastinal and subcutaneous emphysema may occur with high pressure of gases in the trachea.

8. The adenotome may sever the lower end of the tube during tonsillectomy, and the patient aspirate the tube.

9. Positive pressure may obstruct pulmonary blood flow if too high a pressure is maintained with pulmonary ventilation.

10. Coughing and straining may increase venous pressure during light anesthesia.

11. Tracheitis, laryngitis, pharyngitis, rhinitis, or subglottic edema may arise following extubation, usually as a result of using contaminated endotracheal tubes, too large a tube, or prolonged intubation.

12. There is obstruction to airflow with very small tubes.

13. Granuloma of the vocal cords may occur in adults, but is not seen in children.

Scrutiny of the above disadvantages of endotracheal anesthesia will reveal that they are largely technical, and seldom are any of these disadvantages witnessed when care is exercised by a capable anesthesiologist. It may be ventured that subglottic edema is the only disadvantage of endotracheal intubation. This may occur in a mild form following extubation, but if the patient is forthwith placed in cold, moist atmosphere, rarely does this complication become serious. Throughout 25 years of endotracheal anesthesia in infants and children only four patients had tracheostomies, and during the last ten years only one had a tracheostomy. Moreover, with our present knowledge, it is doubtful that under the same circumstances any of these tracheostomies would be necessary today. For example, in our hospital, during 1958, 3,900 infants and children were intubated, and no tracheostomies were required; and there was only one instance of severe subglottic edema, which required the constant attendance of the anesthesiologist the first night postoperatively to ensure that cold, moist atmosphere was applied effectively. As a rule, employment of cold, moist atmosphere for a day or two is sufficient to overcome the edema. Nevertheless, the patient must be observ-

ed closely, for the insidious onset of atelectasis is sometimes a further complication. If atelectasis occurs, it may be necessary to aspirate the trachea to promote coughing.

To reduce to a minimum the complications of endotracheal anesthesia, the following suggestions regarding equipment and procedure are offered:

Equipment

For infants and children there is a wide variation in sizes of laryngoscopes and endotracheal tubes. For each intubation, the anesthesiologist should select the proper size of laryngoscope, endotracheal tube and connector, lubricant for the tube, a doughnut-shaped head rest, and a bite block.

Several laryngoscopes are obtainable which have three interchangeable blades of varying lengths. In a pediatric hospital, an infant laryngoscope along with the small and medium changeable blades of the adult laryngoscope serves all purposes. Immediately after the laryngoscope is used, the blade is scrupulously scrubbed with soap and water, rinsed with a copious flow of water, and dried.

Several important features, negligible in adult anesthesia, make the choice of an infant's or child's endotracheal tube difficult. The wall of the tube must be as thin as is consistent with adequate firmness, especially important in tubes for smaller infants, where a thick-walled tube would slow the airflow in and out of the lungs. These tubes are made of either rubber or plastic. A thin-walled, firm tube is easy to insert even during severe laryngospasm.

Much of the obstruction to airflow in endotracheal anesthesia in infants is due to the small connectors and their design. This difficulty can be overcome in part by inserting the largest possible connector into the endotracheal tube.

The tube should be large enough in diameter to fit the glottis snugly, but not tightly. The length of oral endotracheal tubes can be measured approximately by taking the distance from the tip of the nose to the lobe of the ear, and adding one to two cm. to this measurement in infants, or two to five cm. in older children.

As soon as possible after extubation, the endotracheal tubes and fitted connectors are cleansed with soap and water. A pipe cleaner is passed down the lumens of the smaller tubes; in the larger tubes a small brush is used for this purpose. The tubes are soaked in aqueous zephiran, 1:1000, and washed thoroughly. In addition, once a week all endotracheal tubes are again sterilized in the above manner.

As a lubricant, at present we use sterile pontocaine (one-fourth per cent) jelly. A fat-free water soluble base is used both to prevent the deterioration of the tube and to avoid the entrance of a lipoid into the lungs. A small amount of the jelly, kept in stoppered

collapsible tubes, is applied to the endotracheal tube just prior to insertion.

A headrest is not essential, but helps to elevate the head and keep it from rolling laterally. The convenient doughnut-shaped headrest designed by Waters is very satisfactory.

The anesthesiologist should have some means of keeping the teeth apart following intubation. This can be a tightly rolled plug of gauze with a long tape on it which can be strapped to the outside of the cheek, preventing the gauze roll from falling into the pharynx. A pharyngeal airway or a mouth gag serves the same purpose.

Intubation Procedure

With all the endotracheal equipment ready at hand on a table, the patient is anesthetized to the point of relaxation of the jaw muscles and obtundation of laryngeal and pharyngeal reflexes. For skill, dexterity, speed, and gentleness, it is convenient to follow a definite routine:

1. The headrest is placed under the patient's head.
2. The endotracheal tube is lubricated and placed on a clean towel to the right of the patient's head.
3. The laryngoscope light is tested again and then the laryngoscope is grasped firmly by the handle in the left hand. Better control of the laryngoscope can be obtained by holding the handle down near the blade.
4. At the last moment the anesthetic mask is removed from the patient's face.
5. The palm of the right hand presses backwards on the forehead, extending the head and neck.
6. The tip of the right middle finger opens the mouth and depresses the lower lip.
7. The laryngoscope blade is inserted into the right side of the patient's mouth with the handle of the laryngoscope first pointing toward the patient's right shoulder, since otherwise it may bump against the chest. After the blade is inserted into the mouth, the handle can be swung around to the midline. The anesthesiologist holds his left elbow close to his side, and his left hand on the laryngoscope lifts the lower jaw forward and upward. If properly executed, no pressure is exerted on the upper teeth or gum margin.
8. The tip of the laryngoscope blade is advanced down along the right side of the tongue, and lifts the tip of the epiglottis forward. A good exposure of the glottis is now obtained.
9. The endotracheal tube is now picked up with the tips of the thumb and index finger of the right hand, and the end of the tube is guided down into the glottis. The view of the glottis must be maintained during the insertion of the tube, accomplished by looking down the laryngoscope and bringing the

endotracheal tube in from the right side, down near the tip of the blade.

At this point, there is a slight variation from adult intubation; in order to insert the proper sized tube, it may be necessary to rotate the tube through 180 degrees as it is being passed through the glottic opening.

10. The laryngoscope is removed gently from the mouth. A wise precaution is to hold the endotracheal tube in place with the right hand while this is being done.

11. The connector of the endotracheal tube is attached to the anesthetic apparatus and the lungs inflated immediately with oxygen.

12. The bite block is placed between the teeth.

13. The head is taken off the headrest and the headrest placed under the patient's shoulders.

14. The tube may be strapped to the face with adhesive.

When using a Macintosh laryngoscope a different procedure is followed. The laryngoscope blade is inserted in the middle of the mouth and the tip of the blade is pushed firmly into the base of the tongue, superior to the epiglottis. This causes the epiglottis to rotate anteriorly so that the glottis comes into view. In infants, because the hyoid and thyroid bones are fused and the epiglottis is small and is angled more posteriorly, we find it preferable to use the straight blade. However, in other instances, the Macintosh laryngoscope is very satisfactory.

Some anesthesiologists intubate awake newborn infants or patients with partial respiratory obstruction. This is considered safe, since spontaneous respiration is maintained.

Extubation

The patient is extubated during either deep or light anesthesia, but when spontaneous respiration is present. The pharynx and endotracheal tube are aspirated frequently with a soft rubber catheter and the lungs inflated with oxygen. In deep anesthesia extubation, the endotracheal tube is removed, an oropharyngeal airway inserted, and a mask and bag with high oxygen concentration applied to the face. Should any indication of vomiting occur, the patient is placed in the lateral Trendelenburg position for gravity drainage.

Severe laryngospasm with alarming cyanosis sometimes follows extubation. Sustained laryngospasm can be avoided by extubating the patient during extremely light anesthesia, since in this condition, the respiratory centers are not obtunded by the anesthetic agent. The occurrences of severe laryngospasm can also be reduced by gentle extubation coincident with exhalation.

As further evidence of the benefits of the endo-

ANESTHESIA / Leigh

tracheal technic, in contrast, the disadvantages of the pharyngeal insufflation technic are presented:

Disadvantages of Pharyngeal Insufflation Anesthesia

1. Only minimal preanesthetic sedative can be given, otherwise respiratory arrest may occur during the prolonged induction.
2. The unpleasant, prolonged induction period may be punctuated with laryngospasm, breathholding, and hypoxia.
3. There is reduced oxygen and increased carbon dioxide in the inspired air, especially when an open drop ether mask is blanketed with towels to hasten the induction.
4. There is progressive hypoventilation as the depth of anesthesia increases.
5. Early metabolic acidosis and dehydration occurs during ether anesthesia.
6. Convulsions occasionally are seen during vine-thene ether induction.
7. Choice of anesthetic agent is limited to ether.
8. Surgeon and anesthesiologist breathe ether vapors.
9. A deep stage of anesthesia is essential to provide a desirable operative field and avoid laryngospasm. It is difficult to maintain a stable level of anesthesia. Laryngospasm raises the venous pressure, increases bleeding, and causes hypoxia.
10. The mouth gag, if opened widely, may obstruct the airway.
11. An assistant is necessary to elevate the tongue and aspirate the blood, although a Davis mouth gag can be used to help elevate the tongue.
12. There is no control of the airway or of the pulmonary ventilation.
13. As guardian of the airway, the otolaryngologist shoulders a greater moral and legal responsibility for the safety of the patient, and is therefore not

free to give his undivided attention to the surgery.

14. Recovery from anesthesia takes longer than after endotracheal anesthesia, and there is a constant threat to the safety of the patient from respiratory obstruction and aspiration of vomited blood.

Summary

In summary, the prolonged induction, deep anesthesia, limited choice of anesthetic agents, inadequate control of oxygen—all characteristics of pharyngeal insufflation—are violations of safe anesthesia and this technic should be resorted to only when the physician is not proficient in managing endotracheal anesthesia. On the other hand, the overwhelming advantages to the patient in the form of comfort and safety afforded by the endotracheal technic make it the preferable anesthetic procedure for otolaryngologic operations.

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PLAINS SHOWS INITIATIVE IN OBTAINING PHYSICIAN

PLAINS, LIKE MANY a community its size, in recent years has wanted a physician to set up a general practice there.

Unlike their contemporaries in a number of other towns, though, the citizens of Plains went considerably further than merely issuing an invitation to prospects.

They formed a development corporation, purchased stock, and constructed a modern building in order to provide adequate headquarters for a doctor.

Their efforts paid off the other day when Dr. Carl Sills of Jackson, Miss., and his wife, a registered nurse, rented the building with an option to purchase it.

Thus a happy climax unfolded—one which we hope will be beneficial through the years to all concerned and will provide deserved relief for Dr. J. C. Logan who has served the community for more than 50 years and is the current "Physician of the Year" in Georgia.

—Atlanta Constitution

SOME COMMENTS CONCERNING LUNG CANCER

J. P. Woodhall, M.D., Macon

AN ANALYSIS OF the 101 histologically verified cases of lung cancer treated at the Macon Hospital, Macon, Georgia, between July 1950 and July 1958, shows that one case has achieved a five year cure and that four additional cases have progressed sufficiently so that they may survive five years following treatment. If all five cases should survive five years, the national average for cure in unselected cases will be approximated. This is an appalling record, and it is the purpose of this paper to discuss the reasons for the failure of physicians to meet the problems produced by the steady rise in the incidence of lung cancer.

In this series of cases (See Table I) 33 proved to be inoperable on exploration and 30 were resected. Of the total 101 cases, 71 were thus lost to cure early.

Of the eight lobectomies one died following an ill-advised resection of an inoperable lesion. Of the 21 pneumonectomies, five died postoperatively—two of coronary occlusion, one of pulmonary embolism, one of insufficient functioning pulmonary tissue, and one of a change in the clotting mechanism of the blood not understood in 1952. One case treated by wedge resection (due to an inaccurate frozen tissue diagnosis) died of distant metastases 30 months following surgery. Thus of a total 101 cases, only 24 had any hope for cure under present methods of therapy. Of these 24, eight were living as of July 1958.

TABLE I
Analysis of 101 Cases of Pulmonary Neoplasm

THERAPY	
No treatment	8
Refused treatment	4
Exploratory Thoracotomy (Unresected)	33 (2 deaths)
Radiation only	26
Pneumectomy	21 (5 deaths)
Lobectomy	8 (1 death)
Wedge resection	1
101	

The follow-up experience in this series is disappointing, as generally is surgery of lung cancer.

The lobectomies done generally for smaller lesions fared best. Two appear to be cured, two are living without recurrence but prostatic cancer and hypertensive cardiovascular disease respectively will preclude cure, and the other three survivors lived well until the terminal phase of their disease, an average of 11 months.

Of the 16 pneumonectomies who survived surgery, three are free of disease, one each at 4-5 years, 3-4 years, and 2-3 years. Twelve lived an average of seven months following surgery, half dying of recurrent malignancy. One alive six months as of July 1958 is now dead of metastases. Thus of 16 pneumonectomies, 13 received but short palliation and this was a very disappointing finding. Since 1953 the so-called radical pneumonectomy has been performed in an effort to improve therapy. The material available here is too small to draw any conclusions, but on the face of it, the radical pneumonectomy provides a more logical cancer dissection.

To summarize: Of 101 cases, 63 were operated upon, 30 were resected, 24 survived resection, and of these, five may have achieved the desired objective of therapy.

Table II lists the cell types found in these 101.

TABLE II
Analysis of 101 Cases of Pulmonary Neoplasm

PATHOLOGICAL DIAGNOSIS	
Squamous Cell Carcinoma	60
Anaplastic Cell Carcinoma (Small Cell)	28
Adenocarcinoma	6
Alveolar Cell Carcinoma	2
Malignant Cells Pleural Fluid	5
101	

It may be stated categorically that if an individual develops a small cell hilar growth, early diagnosis from symptoms is unusual, and if resection is possible, cure will rarely follow. Early infiltration of the mediastinum generally prevents resection. Our longest survivor in this group lived 30 months following pneumonectomy. Patients who demonstrate malignant cells in the pleural fluid are not candidates for exploration. It has been my experience that if any free fluid is present within the thorax, the resectability rate is greatly reduced. Basically in this series all patients were explored who did not have neoplastic involvement of the carina, distant metastasis, malignant cells in the pleural fluid, or advanced lesions present in individuals in hopeless physical condition. Kirklin et al¹ have demonstrated that exploration in the face of a preoperative diagnosis of small cell cancer is followed by meager results. Certainly the surgeon should be reluctant to advise exploratory thoracotomy for such lesions when this cell type is found preoperatively.

"Incurability" of Lung Cancer

It is apparent that a portion of the "incurability" of lung cancer is due to cancers which metastasize early or are of a cell type not amenable to surgical cure. The failure to make an early diagnosis in such cases is meaningless since their control appears to be beyond our present means of therapy.

It is difficult to measure this obligate loss. At the present perhaps from one per cent to 10 per cent of lung cancers are being cured by resection. Resection on the average is done in one-third of the cases seen and five year cures in this group apparently range from 20 per cent to 38 per cent with all sorts of qualifications depending upon how the given material is being reported. There is no standard method of reporting except that in this unfavorable type of material emphasis is placed upon the resected cases. Rienhoff² in a singularly concise and lucid report of 669 cases operated upon gives a five year survival for total pneumonectomies of 7.5 per cent; for those subjected to lobectomy, one per cent; and for the entire series of 669 cases, 0.04 per cent. But there is no mention of those cases denied or refusing surgery whose listing would certainly give a clearer view of the total problem.

At the present time surgeons resect in the neighborhood of one-third of the cases seen. Thus two-thirds never received definitive therapy. The surgeon's obligate loss, thus, is two out of every three patients. The obligate loss due to the biodeterminism of the tumor rather than to failure of early diagnosis is unknown. However, it must be considerably lower

than the loss now faced by the surgeon when two out of every three cases represent advanced tumor growth.

In this series of cases only five asymptomatic coin lesions were found by routine X-ray examination. All of these were discovered in private patients during routine physical examination. Of these, four are alive at present (one with prostatic malignancy) and one lived 30 months following wedge resection. All solitary lesions of this type are resectable. Concomitantly, it should be recalled that the large advanced lesions we see so commonly were once small and apparently insignificant, easy to resect, and often of a curative cell type. Rigler³ in a brilliant retrospective study of 100 proved lung cancer cases demonstrated that over half the patients had X-ray evidence of the disease more than two years before symptoms appeared or a definite diagnosis was established. In many of these cases the lesion arose peripherally and extended centrally. The inference of this work is obvious: in the usual case the lung cancer has been present long before the diagnosis is made and in this early stage would have been resectable.

Table III lists the means by which the initial tissue diagnosis was made. Papanicolaou studies were not done early in this series and only in recent years have we used it routinely. Often bronchoscopy is performed before the sputum smears or blocks are reported. Often we reserve the use of sputum smears for diagnostic problems or for inoperable cases whose condition does not warrant bronchoscopy or exploratory thoracotomy. Needle biopsy we reserve for use in inoperable cases when diagnosis cannot be established by other means. Bronchoscopy and exploratory thoracotomy are the major means of establishing a tissue diagnosis.

TABLE III
Analysis of 101 Cases of Pulmonary Neoplasm

INITIAL TISSUE DIAGNOSIS	
Needle Biopsy	1
Pap Smear Sputum	1
Autopsy	2
Pleural Fluid Aspiration	5
Bronchoscopic Washings	5
Biopsy Metastatic Lesion	16
Bronchoscopic Biopsy	25
Exploratory Thoracotomy	46
	101

In this series of cases there has been a considerable delay between the onset of observable lung cancer and the attempt to correct the situation. There has been but little doctor delay; indeed the most unconcerned or superficial of us could tell in most of these cases that an ill patient with lung pathology had entered the office. Doctor delay then was no problem and two conclusions may be inferred: first,

that often the disease was obvious, and secondly, the physicians had a reasonable level of suspicion concerning this disease. This latter, I believe, is a tribute to the many surgeons in this field who have emphasized repeatedly the frequency of lung cancer and the diagnosis of lung cancer.

Patient delay was a tremendous factor in the poor results achieved in treating them. This delay was due either to economic insecurity or ignorance.

Statistics for doctor delay in the diagnosis of lung cancer and patient delay in seeking help are often recorded. Doctor delay was not a significant factor in this series. It is extremely difficult to determine the delay due to the patients in this series, that on the average it was long—well over six months—is apparent. Such statistics—so often achieved by estimation—are not helpful to the surgeon who treats these patients. He knows, above all, that the treatment of asymptomatic lesions is followed by the best results; that symptoms apparent to the patient—weakness, weight loss, hoarseness, chronic cough, fever, pain, and hemoptysis—often indicate advanced pathology. *For optimal results surgery must be performed before the patient becomes a symptomatic case of lung cancer.*

Economic Fear Delays Help

Economic fear was a frequent cause for patient delay in seeking help. So often in lung cancer the adult male head of the family is the victim. Males suffer this disease in an 8-1 ratio over females; the bulk of the cases occurring after the age of 40. Thus the necessity of maintaining the family economically will keep some men working long after they know they are ill, and farmers, particularly, will put in a crop, harvest a crop, do both, or start all over again before they will seek help. By then inoperable lung cancer all too frequently is present and for most, death follows the best of motives.

The economic loss to the family when the head of the household becomes ill is obvious. The economic loss to the community in the aggregate is difficult to assess but it must be considerable. Still, the threat of economic loss due to the felt illness keeps many men from achieving earlier diagnosis and possible cure through treatment.

Disability insurance, unemployment insurance, and the aid from public welfare organizations when private means do not exist are our present methods of obviating the economic fear which keeps individuals from seeking earlier help. These methods have not proven acceptable to many and these people do not appear in a physician's office until weakness, pain, or fear of death forces them to that step.

Ignorance is the greatest deterrent to the achievement of more acceptable cure rates in lung cancer.

People simply do not know enough about this disease or what steps they must take to protect themselves i.e., achieve earlier diagnosis. It is not enough for doctors to be cognizant of this disease, to be able to diagnose this disease, or to be able to treat this disease. The physicians must be exposed to patients in the early stages of lung cancer or else their professional talents, whatever they may be, will be wasted. We know that due to late diagnosis many lives are sacrificed needlessly. This is distasteful, unpleasant knowledge.

At the present time the only way surgeons will cure more patients is by having more patients in an earlier stage of the disease. It is often stated that every physician should include chest films in his examination of male patients over 40. But it is apparent that not all males over 40 see physicians or if they should be subjected to one chest film, do not have chest films at six to 12 month intervals thereafter. Within the medical profession it is the rare doctor who submits himself to regular physical examinations, that is until some catastrophe strikes him or one close to him. Then we see the X-ray machine glowing hot from overuse and the EKG machine piling reams of hieroglyphics upon the floor! But what great cooperation we expect from patients! And yet it is a matter of education and proper emphasis to produce a better informed public—not until then will we achieve better results in the treatment of lung cancer.

The public must be continuously informed of the value of periodic physical examinations and these examinations should include chest X-ray studies. The public should be instructed as it has been in the past for other diseases in the frequency and importance of lung cancer. And, finally, we should list again and again the medical facilities available to the public, available to them for the single purpose of securing and maintaining their health.

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PATHOLOGIC AND ANATOMIC FACTORS IN BACK PAIN

Excessive functional strain may result in the early appearance of degenerative changes in joints and intervertebral disks.

Paul Reith, M.D., *Atlanta*

PATHOLOGICAL AND ANATOMICAL data as a contribution to the causes of local back pain has not been highly significant in the past. Clinical observations and findings like Mixter and Barr's¹ important observation of the extrusion of an intervertebral disk to sciatic pain as reported in 1934 have, for the most part, represented the historically prominent contributions. More recent interests indicate the possibility of a return toward basic medical sciences for broader knowledge in still frustrating topics like the etiology of back pain.

Genitourinary, gynecologic, or gastrointestinal pathologic lesions are not to be detailed in this paper except to mention kidney, uterine, rectal, pancreatic, intestinal, and retroperitoneal lesions, especially aortic or iliac arterial lesions, as not infrequently being associated with symptomatic back pain.

Similarly, emotional or psychogenic factors are not usually included in a pathological discussion, except by way of review of a subject of equivocal etiology. An example of this is what Kellgren² calls the "mythology of fibrositis" whereby it appears that the theories of pathogenesis and etiology of this entity have failed to survive critical evaluation. Included in these theories were the concept of "inflammation of white fibrous tissue," the once-popular fibrositic nodule, the theory of interstitial neuritis with segmental pain, the more recent "mythology . . . about trigger points and . . . cycle pain mechanisms . . .". Nonetheless, a few writers³ still describe fibrositis as an inflammatory reaction in fibrous connective tissue, and even the causative role of focal sepsis has been revived by other.⁴

Accumulated experience appears to indicate that so-called "primary fibrositis" is, in fact, secondary to underlying disease such as degenerative arthritis,

rheumatoid arthritis, "collagen diseases" such as dermatomyositis, polymyositis, periarteritis, or some types of calcinosis, and intervertebral disk lesions.

The role of psychic and emotional stress is emphasized in other so-called "secondary fibrositis" cases. The musculoskeletal expression of anxiety-tension states, termed psychogenic rheumatism or myalgia, is stated to account for as many as 40 per cent of patients attending some rheumatic disease services. This psychoneurosis may occur as a functional overlay of minor organic disorders, or as the prolongation of symptoms of a previous organic illness. These tense, anxious, resentful, or hostile patients sometimes express their resentment, often subconscious, in sustained muscle tension with accompanying muscle tenderness, or with excessive perspiration with cold extremities, or with hyperreflexia and tremor, or with other manifestations of disturbed autonomic function. Two well documented studies⁵ have shown the correlation of electromyographically measured muscle tension with psychodynamic attitudes of anxiety, hostility, and resentment.

"Primary Fibrositis"

"Primary fibrositis" and fasciitis, as seen in the shoulder-hand syndrome or in Dupuytren's contracture, may possibly occur to a lesser degree in posterior cervicobrachial or lumbosacral fascial layers. Moberg⁶ feels that the primary pathologic factor is immobilization with resultant absence of the "pumping mechanism" of the return blood flow, and consequent stasis.

Degenerative changes of intervertebral disks and vertebral column joints deserve special emphasis since degenerative disk and joint disease constitutes the numerical majority of pathologic spinal lesions.

The relationship of disk derangement and degen-

Presented at the *105th Annual Session of the Medical Association of Georgia, May 17, 1959, Augusta, Georgia.

eration is thought to be associated with locally altered carbohydrate and protein metabolism, but this specific alteration lacks clear understanding at this time. The state of hydration of the nucleus pulposus can be more clearly determined, however, and aging, dehydration, and degeneration with fragmentation and fibrosis appear as concomitant findings.

Disk degeneration can also be induced as pressure atrophy. The disk spaces that are subjected to the greatest pressures, the widest ranges of movement, and the greatest posterior compression and shearing forces, usually show earliest and most advanced degenerative changes. Acute increase of intervertebral disk pressure with disk rupture has been reported and observed in aircraft pilots from positive acceleration.

Structural deterioration of vertebral disks and joints is also associated with postural evolution of orthograde man. Conversion toward planograde posture is often a pain-relieving position in discogenic-radicular disorders, and may be of diagnostic, as well as therapeutic importance.

Muscle imbalance of the trunk, contractures, and deformities, e.g., hip ankylosis, uncompensated leg length discrepancies, scoliosis, lordosis, congenital anomalies, e.g., transitional vertebra, spondylolisthesis, spondylolysis, hemivertebrae, or primary or secondary instability may predispose to structural deterioration of spinal disks and joints. The level of maximum disk and joint degeneration is often noted to be located one segment cephalad of the predisposing anomaly, e.g., when the fifth lumbar is a transitional vertebra, disk, and joint degeneration is often maximal at the lumbar four-five level.

The relationship of disk degeneration, collagen disease, disk calcification, and fibrositis has been re-

ferred to but remains uncertain and doubtful. Multiple disk lesions in the same individual requiring multiple surgical procedures, or multiple lesions of similar nature within an immediate family suggest the possibility of a common metabolic or hereditary abnormality. Disk calcifications are not frequent, usually remain dormant and silent, may be seen in children as well as adults at any spinal level, may even disappear, or may rarely protrude. Definite relationship of this entity to calcinosis, collagen disease, or calcareous tendinitis has not been established.

Summary

In summary, it appears that degenerative changes of intervertebral disks and joints are essentially evidence of the wear and tear phenomena of aging in which excessive functional strain may result in early appearance of the process, or, as Bradford and Spurling⁷ state, early decadence of the disk contributes to its vulnerability.

1355 Harvard Road, N.E.

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HELP FOR FAMILY OF CANCER PATIENT

A NEW PAMPHLET designed to assist the families of cancer patients meet the difficult physical and psychological problems connected with that disease has been issued by the Public Affairs Committee in cooperation with the American Cancer Society.

Written by Elizabeth Ogg with the assistance of several medical groups specializing in cancer research and

treatment, the pamphlet suggests ways of "handling the situation created by your relative's cancer with a minimum of mental suffering." It also contains specific advice on preparing for surgery and rehabilitation after surgery. The latest of the non-profit Public Affairs Pamphlet series, it is available for 25 cents from the Committee's office at 22 East 28th Street, New York 16.

SOUTHERN MEDICAL ASSOCIATION TO MEET IN ATLANTA

To the Doctors of Georgia:

Your thousands of friends throughout the territory of the Southern Medical Association, would like to remind you that we are coming to visit the state of Georgia, as well as the good city of Atlanta, on November 16-19. Atlanta will be the center of our visit but we value and appreciate also the cities, the professional facilities, and the good people throughout the host state.

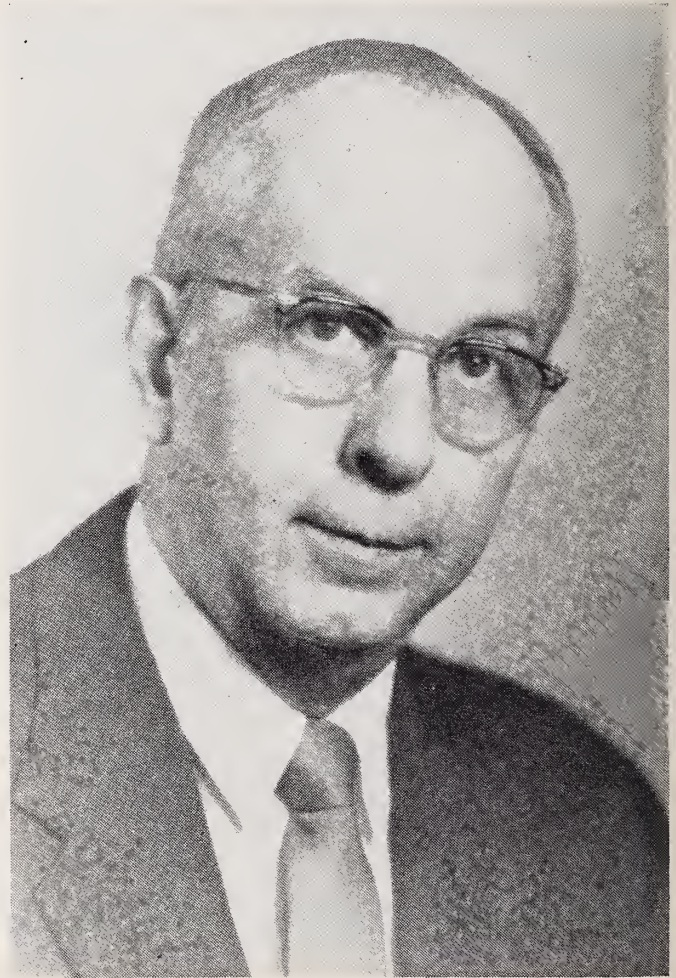
To those of you living in Georgia, it may not be the treat that it is to us to spend four or five days in the beautiful, hospitable City of Atlanta—because you are there fairly often, but I know you will agree with us that a more delightful locale cannot be found for several days experience in the “laboratory of good fellowship” which is Southern Medical.

You are the only state group that could hope to have 100 per cent registration during Southern’s meeting, because you are close enough to run in for at least two days of the meeting, even if you have to exchange responsibilities with one of your confreres. How fine it will be for Georgia to set a new record of high percentage registration of physicians from the host state—and I believe you will do it!

Our wives are coming with us also and are looking forward to the privilege of meeting your wives in Atlanta. One of the biggest attractions of Southern Medical is the gracious hospitality of the good ladies.

Section Officers and Chairmen of general sessions and symposia have built a superb scientific program, and scientific and technical exhibits will reach a new height of excellence. There will be an unusual number of section, alumni, fraternity, and small group social affairs that will combine to make this the best meeting Southern has ever experienced.

When you receive your preliminary program in a few days’ time, confirm for yourself what I have



said and then write at once for your hotel reservations—unless you are close enough to drive daily.

We are really coming to Georgia in November and will expect to see you in Atlanta.

Most cordially,
Milford O. Rouse, M.D.
President, Southern Medical
Association

1960 *Annual Session*

May 1-4, 1960 – Municipal Auditorium, Columbus, Ga.



Final Call

for

Scientific Papers

All titles must be submitted to the respective
program chairmen listed below before
November 1, 1959.

ANESTHESIOLOGY

George E. Donaghy
St. Francis Hospital, Columbus

CHEST

Robert H. Vaughan
Medicol Arts Building, Columbus

DERMATOLOGY

Dave Berman
1315 4th Avenue, Columbus

DIABETES

John K. Davidson
Doctors Building, Columbus

EENT

Floyd C. Jorrell, Jr.
Doctors Building, Columbus

GENERAL PRACTICE

C. Denton Johnson
13 13th Avenue, Columbus

MEDICINE

Simone Brocato
Physicians Building, Columbus

**NEUROLOGICAL SURGERY AND
NEUROLOGY**

Louis Hozouri
1525 13th Avenue, Columbus

OBSTETRICS AND GYNECOLOGY

P. C. Groffognino
Medicol Arts Building, Columbus

ORTHOPEDICS

Jack C. Hughston
Medicol Arts Building, Columbus

PATHOLOGY

Wroy J. Tomlinson
The Medicol Center, Columbus

PEDIATRICS

Mercer Blonchord, Sr.
204 11th Street, Columbus

PSYCHIATRY

Luther J. Smith
1509 4th Avenue, Columbus

RADIOLOGY

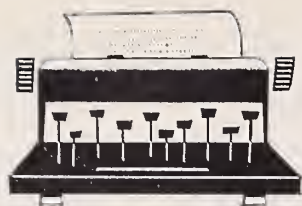
George Hutto
Medicol Arts Building, Columbus

SURGERY

S. A. Roddenbery
711 Center Street, Columbus

UROLOGY

Franklin D. Edwards
1430 Center Street, Columbus



editorials

The Georgia Accrediting Program for Smaller Hospitals

IN THE STATE OF GEORGIA there are approximately 65 hospitals of 25 beds or less. The majority of these smaller hospitals are striving to maintain high standards—yet they do not get the recognition awarded larger hospitals. The Georgia Hospital-Medical Mediation Council is making an effort to give recognition to smaller hospitals with a plan somewhat similar to the program of the national Joint Commission of Accreditation of Hospitals.

Accrediting programs for hospitals was originated by the American College of Surgeons as a direct outgrowth of the requirements that each applicant write 50 case histories. The applicants found their own records were inadequately prepared to justify diagnosis, treatment, and explain end results. Dr. Franklin H. Martin and Dr. John D. Bomar, then Secretary General and Director respectively, of the College prepared minimum standards for hospitals.

By the year 1950, the American College of Surgeons had spent two million dollars on the program of hospital accrediting and it was apparent the yearly cost of the project was too great for a single organization. A study was initiated which resulted in the formation of an independent non-profit corporation in 1952. This corporation, the Joint Commission of Accreditation of Hospitals then assumed the responsibility of approving hospitals. The corporation

is composed of representatives of the American Medical Association, American Hospital Association, American College of Surgeons, American College of Physicians, and the Canadian Medical Association.

However, at the present time because of the magnitude of the job undertaken by the Joint Commission, hospitals of under 25 beds are not inspected.

The Georgia Hospital-Medical Mediation Council, organized one year ago, has approved and published "Standards for Smaller Hospitals" and is at present visiting Georgia's smaller hospitals and presenting this accreditation program. The Georgia Council is composed of seven major statewide organizations which include the Georgia Academy of General Practice; Georgia Chapter, American College of Surgeons; Georgia Association of Hospital Governing Boards; Georgia Chapter, American College of Hospital Administrators; Georgia Department of Public Health; Georgia Hospital Association; and the Medical Association of Georgia. Through the combined cooperation of these statewide organizations, the smaller hospitals in Georgia will receive due recognition in the form of accreditation certificates under the provisions of this program of Standards for Smaller Hospitals.

John T. Mauldin, M.D.

Welcome Southern Medical

THE DOCTORS OF GEORGIA are looking forward with anticipation to the 53rd annual meeting of the Southern Medical Association to be held in Atlanta, November 16-19. Advance registrations indicate that more than 5,000 physicians will attend this meeting. This four-day session of the Southern represents one of the nation's largest postgraduate medical meetings.

Hosting this meeting will be the members of the Fulton County Medical Society. Some 40 committees made up of 300 physicians from Fulton have been organized to insure a smoothly functioning program.

The two major scientific topics for the session will

be symposia on nuclear medicine and on the growing problem of care for the older patient. In all some 20 scientific section meetings will be held. Nationally prominent leaders from every specialty are scheduled for the program.

A special invitation has been issued to the doctors of Georgia by the President of the Southern Medical to attend this outstanding session. It is hoped that a record number will accept this invitation for several days experience in the "laboratory of good fellowship", which is the Southern Medical. Atlanta and Georgia are honored to be the hosts.

GEORGIA INVESTIGATES ITS STATE HOSPITALS

THE JUNE ISSUE of the *Journal of the Medical Association of Georgia* gives a full report of the study of the Hospital for Mental Patients at Milledgeville. The committee was appointed by the president of the Medical Association of Georgia at the request of Governor Ernest Vandiver. The committee's organizational meeting was held on March 13, 1959, and its completed report was submitted, with recommendations, on April 23. The investigation revealed that a drastic overhauling of the Milledgeville hospital was needed and pertinent recommendations for improvement were offered.

This report should be of particular interest to North Carolinians, since similar surveys have been made in this state. There is the important difference that the entire expense of the Georgia investigation was borne by the State Society, and that all members of the Georgia board were doctors. Previous surveys had been made in both states—at least 12 in Georgia since 1913, and at least two in North Carolina before the Umstead Committee's report in 1945. The most thorough one made in North Carolina lasted for a year—October, 1935 to October, 1936—and was financed by the Rockefeller Foundation. The late Dr. Fred M. Hanes was chairman of this commission, and Dr. Lloyd J. Thompson was borrowed from Yale to direct the survey. This really monumental work of 377 pages was transmitted to Governor Ehringhaus, with the expectation that it

would be submitted to the General Assembly in 1937. One sentence in Dr. Hane's letter of transmission, however, proved to be prophetic: "It is too often the fate of official reports to find themselves quietly interred in the oblivion of dusty pigeonholes."

Six years later a series of melodramatic articles by Rev. Tom Jimison, a patient in the State Hospital at Morganton, reawakened public interest, and Governor Broughton appointed a Board of Inquiry, which resulted in the appointment of an over-all Board of Controls, and some improvement in the State Hospitals. Unfortunately, the 1943 General Assembly ignored the most important recommendations of the Broughton board, which were aimed at keeping the conduct of the state system of hospitals as free as possible from political control.

In 1945 another investigation was headed by Mr. John Umstead. The legislatures in 1947 and 1949 made generous appropriations for permanent improvements in the State Hospitals. In 1947 Butner was purchased from the federal government for a fraction of its real value. Since then real progress has been made in the care of the unfortunate victims of mental illness.

This *Journal* extends to the doctors of Georgia, with heartfelt congratulations on the splendid accomplishment of a disagreeable, highly important duty, the heartfelt hope that this thirteenth survey may prove to be the lucky one, and that, in the words of Governor Vandiver, it may form "a worthwhile chart for future progress in the mental health field."



heart page

REHABILITATION OF THE STROKE PATIENT

JACK B. MOHNEY, M.D., *Augusta*

AMBULATION OF 75 to 90 per cent of all stroke patients who survive the acute episode is possible. The hemiplegic who survives deserves the development of a hopeful attitude and outlook to the possibility of being as useful and independent as possible.

The basic program concerning a physician-controlled home rehabilitation program is well presented in the pamphlet, "Strike Back at Stroke." A motion picture entitled *Second Chance* is available to all physicians and lay groups who are interested in this program. It shows the methods used in the rehabilitation of a stroke patient. Stroke Clinics have been established at Albany, Atlanta, and Savannah with a primary aim of acquainting the patient who has had a stroke, and his family, with a home program of rehabilitation. The Georgia Heart Association has made the program of rehabilitation of stroke patients its paramount project for the next two years. The success of this program is dependent on the participation of all physicians who see this type of patient.

The depression of function by the lesion is often secondary to the neural shock and cerebral edema present in the early phase of the disease. Moderate return of activity of the extremity in the first month usually signifies that the extremity will be reasonably functional. If moderate return is not noted during the first three months after onset, the possibility of function to a useful degree is greatly diminished. There are, however, a significant group of patients who show essentially no improvement for a few

weeks, but do gradually improve. One should not give up the case as hopeless until at least six to nine months after onset.

The care of hemiplegics in the early phase is basically life-saving in nature. However, one must not overlook the fact that tightness, loss of strength, atrophy of muscle, frozen joints, and decubitus ulcers may occur very early and that motivation for the best possible recovery may completely disappear. The road to invalidism is straight and wide.

The prevention of this dismal outlook is readily modified in most cases. Of major importance in the prevention of tightness and faulty positioning which will lead to deformity, and hence limit recovery, are: (1) the application of exercises in the form of range of motion, (2) correct positioning in bed, and (3) support of the involved extremities. The patient's questions should be answered to minimize anxiety. Those patients who have aphasia can generally hear and may be taught a sign to give that will indicate they understand your explanations. The procedures outlined above are very infrequently contraindicated and may be started as early as two to four days after the onset of the disease.

As the condition of the patient improves, progression of the rehabilitation program to active motion with the aid of the physical therapist, nurse, or member of the family, and even participation of the patient's good side helping the involved side, is indicated. As soon as the physician feels the patient

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

can tolerate activity, he may be gatched up in bed, allowed to sit on the side of the bed, or allowed to sit in a wheelchair. The gradual process of improvement in the patient will allow him to progress to the standing position. Extreme weakness about the knee and ankle, and perhaps later, spasm of muscles of the involved lower extremity, may necessitate the use of a splint which may be bound to the leg with a bandage. If the weakness or spasm is persistent, a short or long leg brace may be required. Support, in the standing position, by a second person is necessary. Standing balance is most important to achieve before the patient attempts walking. One must remember not to tire the patient and to stay within his capability. The upper extremity is, at times, a greater problem than the lower extremity. The occurrence of spasm may necessitate the use of a splint to prevent deformity of the hand. In general, the whole arm should be supported by an arm sling to prevent excessive stretching of the tissue about the shoulder which may result in subluxation.

If there is return of muscle power in the upper extremity, a program dealing with increasing the strength of the arm, hand, etc. can be established. Squeezing a ball for strengthening of the hand and fingers, working at a table moving blocks from one edge of the table toward the other, writing, etc., will increase the range of motion and coordination of the shoulder, arm, forearm, and hand. The program

should be kept simple and within the ability of the patient.

The question which always occurs in the establishment of a program such as outlined is, "Who is to carry this out?" In most sections of the state, we have available to us visiting nurses who have had considerable experience in setting up home programs similiar to the one outlined in the pamphlet, "Strike Back at Stroke." If a nurse is not available, a member of the family, or a friend, may be instructed, and with the aid of this pamphlet can do an excellent job. The interest, support, and encouragement of the physician is of vital importance to the success of their endeavor. Although it is possible to refer the patient to a specialized center for care, many times this is impossible.

The rehabilitation of the stroke patient, sponsored by the Georgia Heart Association, is the first step in placing before us a simple treatment program. This program is adaptable, not only for the stroke patient, but for patients of all ages who have need for rehabilitation. Information of this nature made available to families, who have the problem of the care of the chronically ill patient, will prove invaluable in eliminating the bed-fast patient. To a major degree, this reduces the dependency of the individual on the family or a particular member of the family. Habit incontinence, which is a severe problem, is minimized; nursing care is greatly reduced; and a cheerful attitude is maintained by the patient.

HALL MEDICAL SOCIETY ASKS HIGHWAY ACCIDENT CRACKDOWN

THE HALL COUNTY MEDICAL SOCIETY—disturbed over the large number of area auto accidents resulting in injuries—has passed a resolution urging "strictest administration of justice" in connection with the mishaps.

Dr. P. F. Brown, Jr., president of the society, said today that the resolution, which has been accepted and approved by the Medical Association of Georgia, would be distributed to various civic and professional organizations "in the hope that it would be given some support and be a help in controlling the problem which has reached public health proportions."

The resolution states:

"Whereas, the Hall County Medical Society through its regular work in caring for patients injured in automobile accidents has observed the large number of deaths, temporary, and permanent injuries to the people of this area, and

"Whereas, we have noted that many of these accidents have involved repeat offenders, and

"Whereas, we have noted alcoholic beverages have been a factor in a high percentage of these accidents, and

"Whereas, we have noted that the law enforcement officers have discharged their duties efficiently and effectively, and

"Whereas, we are desirous of stimulating public feeling against these accidents, and to publicize their disabling effects, and by so doing hope to reduce the number of accidents by preventive measures and the fear of the law.

"Now therefore be it resolved, that the Medical Association of Georgia go on record as giving its whole hearted support to the Judicial Officers sitting in judgment on these cases and be it further resolved that those Judicial Officers be encouraged to render the strictest administration of justice."

—Gainesville Daily Times



cancer page

CANCER OF THE COLON

A. B. CONGER, M.D., *Columbus*

CANCER OF THE COLON is distinguished from cancer of the anus, rectum, and rectosigmoid by being beyond the reach of the 25 cm. sigmoidoscope. Such cancers of the colon comprise approximately 35 per cent to 40 per cent of all cancers of the large bowel¹.

The most common symptom of cancer of the colon is *abdominal pain*. This is followed, in a decreasing per cent of patients, by *alteration in bowel habits*, *loss of weight*, *vomiting*, *bleeding*, and *unexplained anemia*. Because of the relationship to food, the pain, with vomiting, etc. is frequently confused with that of an ulcer. If a G. I. series shows duodenal scarring and the patient is anemic and gives evidence of occult blood, this diagnosis is often accepted, sometimes with serious delay.² Colcock³ has reemphasized that in a large group of patients with cancer of the right colon, the initial symptom in almost half were not indicative even of abdominal disease, but were weakness, fatigue, pallor, anorexia, and loss of weight.

A barium enema study should be done for any patient who has abdominal discomfort, weakness, pallor, alteration in bowel habits, fatigue, anorexia, vomiting, or loss of weight. In practically every instance this should be preceded by a sigmoidoscopic examination, and, in many cases, followed by an upper gastrointestinal series.

The manner in which the barium enema is done

is of utmost importance. In a significant percentage of cases reported from various clinics, the barium enema has been negative on one or more examinations when a cancer of the colon was present. Welin⁴ shows that the colon study can be a method of precision and accuracy not generally appreciated by all radiologists, as well as others. He feels that a really clean colon should be obtained by a light diet and castor oil the day before, followed by atropine orally one hour before examination. The contrast enema is immediately preceded by a cleansing enema. Both of these contain an isotin preparation and tannic acid to increase peristalsis and inhibit the secretion of mucous.

Articles describing technical methods for improving the end results in the surgical treatment of cancer of the colon have continued to appear in the literature. All evidence supports the view that resection of the tumor, adjacent intestine, and adjacent lymphatic areas must be as extensive as possible. Tumors of the right colon should be attacked by preliminary ligation of the blood vessels supplying that part of the colon at their origin from the superior mesenteric artery or the aorta. In dealing with these tumors in the proximal transverse colon, the middle and left colic arteries should first be ligated. For tumors in the distal transverse colon and splenic flexure, the middle colic, and inferior mesenteric arteries

Approved by Professional Education Committee, Georgia Division, ACS.

should be first ligated, if possible, and the inferior mesenteric artery ligated for tumors of the left colon and rectum.

The presence of viable tumor cells in venous blood following manipulation of the tumor at the time of operation has been emphasized.¹ Viable tumor cells in the lumen of the colon must also be considered. Preliminary ligation of the blood supply and preliminary ligation of the bowel on both sides of the lesion should help to overcome these possible sources of recurrence or metastases.

In all, our present cure rate in cancer of the colon

can be elevated by education of the patient, by a high index of suspicion on the part of the physician, by adequate and, if necessary repeated x-ray examinations and by early, meticulous and radical surgery.

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3. Colcock, B. P.: Diagnosis of Carcinoma of Right Colon, Post-Grad. Med. 22:151-156, August, 1957.
4. Welin, S.: Modern Trends in Diagnostic Roentgenology of Colon, British J. Radiology 31:453-464. Sept., 1958.

A.M.A. TO HOLD 13TH CLINICAL MEETING IN DALLAS

THE AMERICAN MEDICAL ASSOCIATIONS 13th clinical meeting December 1-4 in Dallas, Texas, will draw some 3,500 physicians, mainly from the southern and southwestern states.

Planned in cooperation with Dallas physicians, the meeting is designed to help the family physician meet his daily practice problems.

Dr. Everett C. Fox, Dallas, is general chairman of the meeting, while Dr. C. D. Bussey, Dallas, is program chairman.

Among the subjects to be discussed on the scientific program are soft tissue injury; whiplash injuries of the neck; diabetes; heart murmurs in children; new laboratory procedures; new resuscitation techniques; premarital and marital counseling; and the problem child.

Dr. Hubertus Strughold, professor of space medicine at the School of Aviation Medicine, Randolph Air Force Base, Texas, will be principal speaker at the opening scientific session December 1. Dr. Strughold, often called "the father of space medicine," will discuss the role of medicine in the space age.

The winner of the A.M.A.'s Distinguished Service Award at the Atlantic City meeting—Dr. Michael E. DeBakey—will participate in a symposium on the surgical considerations of cerebrovascular insufficiency Tuesday afternoon, December 1. Dr. DeBakey, chairman of the department of surgery at Baylor University College of Medicine, Houston, was given the award for his outstanding contributions to medicine in the field of vascular surgery.

The scientific program, including lectures, symposiums, medical motion pictures, color television, and nearly 100 scientific exhibits, will be held in Dallas Memorial Auditorium. Industrial exhibits will number 251.

The auditorium will also house the "world's largest health fair," sponsored by the Dallas County Medical

Society in conjunction with the A.M.A. The fair will run from November 27 to December 7 and will be open to the public.

The fair will feature 150 educational exhibits, prepared by the A.M.A., allied health groups and voluntary health organizations. They will be manned by members of the Dallas society.

Another special feature of the A.M.A. meeting will be a national conference on the medical aspects of sports, to be Monday, November 30—the day before the A.M.A. meeting opens.

The conference, to be held under the auspices of the A.M.A.'s Committee on the Medical Aspects of Sports (formerly the Committee on Injury in Sports) will be open to athletic directors, coaches, and trainers, as well as interested physicians.

The program will cover the general areas of the physiology and pharmacology of exercise, the training and conditioning of the athlete, and the prevention and treatment of injuries.

This is the second time that the A.M.A. has met in Dallas. It held an annual meeting there in 1926. One A.M.A. president has come from Dallas—the late Dr. Edward H. Cary, who was inaugurated in 1932 at the New Orleans meeting.

The A.M.A. House of Delegates, numbering 208, will meet throughout the week at the Adolphus Hotel, meeting headquarters. The first act of the House will be to name the General Practitioner of the Year. The late Dr. Lonnie Coffin, Farmington, Iowa, was the last recipient of the award, given annually to an outstanding American doctor for his medical and civic contributions to his community.

The first recipient of the award was Dr. Archer Chester Sudan, Kremmling, Colo., who received the award at the first clinical meeting in January 1948 at Cleveland.

current clinical concepts

Massive Bowel Infarction and Autopsy Study

EMBOLECTOMY OR THROMBOENDARTERECTOMY for occluded mesenteric arteries is theoretically capable of preventing massive bowel infarction. Of 31 autopsy cases of acute bowel infarction, 19 had fresh occlusion of the superior mesentery artery, three had old occlusions, and nine had no demonstrable occluded major artery to account for the bowel infarction. Over one half of the fresh occlusions were confined to the superior mesenteric artery, with normal distal branches and therefore could have conceivably been surgically treated. In a few cases, occlusions were sufficiently distal to have allowed limited bowel resection.

Glutzer, Donald J., M.D. and Shaw, Robert S., M.D., Mass. General Hospital, Boston, Mass., *New England Journal of Medicine* 260: 162-167, 1959.

Pleural Biopsy and Diagnosis of Pleural Effusion

THESE PHYSICIANS USED blind punch biopsy of the pleura for determining the nature of pleural effusion or pleural shadowing of unknown cause in the total of 228 biopsies on 200 patients. Histologic examination of the biopsy material enabled the diagnosis in about 80 per cent of the tuberculous and 60 per cent of malignant effusions. There was only one false positive diagnosis in this group. The method proved simple and safe with the only complications listed as hematoma, pneumothorax, and secretory deposits along the needle track from a neoplasm.

Mestitz, P.; Purvis, M. J.; and Pollard, A. C., *Lancet* 11:1349-1353, Dec. 27, 1959.

The Tuberculin Reaction in Female Hospital Patients

OF THE 1,356 patients (surgical) tested, 397 (30 per cent) had a positive tuberculin reaction. Three hundred and thirty-one patients with positive tuberculin tests were given X-ray examinations. Of these 203 (61 per cent) were negative for tubercu-

losis; 122 patients (37 per cent) had X-ray evidence of inactive tuberculosis, and six patients (two per cent) had X-ray evidence of active tuberculosis. On the basis of these findings it is believed that the intradermal tuberculin test is an effective method for screening female surgical patients in the New England area.

Taubenhaus, Leon J., M.D., M.P.H., Brookline, Mass., *New England Journal of Medicine* Vol. 261:328-330, No. 7, August, 1959.

From Case Records of the Massachusetts General Hospital

POLYCYTHEMIA VERA HAS BEEN found associated with hydronephrosis as well as with one or two per cent of cases of renal cell carcinomas, cerebellar hemangioblastomas and uterine fibroids. The association is poorly understood.

New England Journal of Medicine, Vol. 261:242, No. 5, July 30, 1959.

Diverticulum of the Female Urethra

THE FEMALE URETHRA must be examined by the McCarthy panendoscope if urethral diverticula are not to be missed on examination of patients with recurrent urinary tract infection.

Wishard, William Niles, Jr., M.D.; Nourse, Myron H., M.D.; and Mertz, John H. O., M.D., *J.S.M.A.* Vol. 52:8, August, 1959.

Vesical Neck Contracture in Children

RECURRENT URINARY TRACT infection in the male or female child is often due to bladder neck contracture with residual urine and ureterovesical reflux. Surgical revision of the bladder neck is the treatment of choice.

Hanten, J. S. (Capt. MC USN); Galuszka, A. A. (Capt. MC USN); and Rotner, M. (Lt. MC USN), *J. Urol.* Vol. 82, No. 2, August, 1959.

Papaya As An Anthelmintic

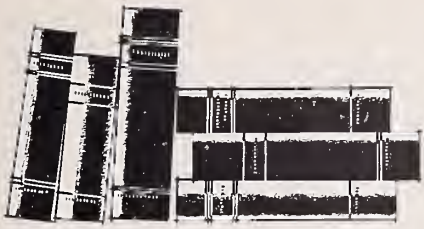
A SINGLE DOSE of papaya seeds results in considerable expulsion of *Ascaris* worms. This is a cheap, nontoxic anthelmintic and also contains nutritionally valuable unsaturated fatty acids.

Robinson, P., *Quarterly Review of Pediatrics*, Vol. 14, No. 2, pp. 117, April-June, 1959.

Intra-Aortic Exchange Transfusions

A TECHNIQUE USING the umbilical arteries instead of the umbilical vein for exchange transfusions in erythroblastosis foetalis is described. The advantages are that blood volume and pressure are kept steady; no syringes or mechanical devices are necessary; catheterization is easy and almost without risk; there is less danger of perforation than when the vein is used; the outflow from the aorta goes smoothly because of the higher pressure when both umbilical arteries are cannulated; and the organs reached first by the infused blood can easily be watched. No fatalities or undue sequelae have been observed in 83 consecutive infants thus transfused.

Saling, E., *Quarterly Review of Pediatrics*, Vol. 14, No. 2, pp. 115, April-June, 1959.



physician's bookshelf

BOOKS RECEIVED

Bocock, E. J., **APPLIED ANATOMY FOR NURSES**, The Williams & Wilkins Company, Baltimore, 1959, 326 pp., \$4.25.

Peck, Joseph H., M.D., **WHAT NEXT. DOCTOR PECK**, Prentice-Hall, Inc., New York, N. Y., 1959, 209 pp., \$3.50.

Ryan, Robert E., M.D.; Thornell, William C., M.D.; and von Leden, Hans, M.D., **SYNOPSIS OF EAR, NOSE, AND THROAT DISEASES**, The C. V. Mosby Company, St. Louis, Mo., 1959, 383 pp., \$6.75.

Havener, William H., M.D., M.S. (Ophth.), **SYNOPSIS OF OPHTHALMOLOGY**, The C. V. Mosby Company, St. Louis, Mo., 1959, 288 pp., \$6.75.

Flatt, Adrian E., M.D., F.R.C.S., **THE CARE OF MINOR HAND INJURIES**, The C. V. Mosby Company, St. Louis, Mo., 1959, 266 pp., \$9.50.

Potts, Willis J., M.D., **THE SURGEON AND THE CHILD**, W. B. Saunders Company, Philadelphia, Pa., 1959, 255 pp.

Robinson, Marie N., M.D., **THE POWER OF SEXUAL SURRENDER**, Doubleday & Company, Inc., Garden City, N. Y., 1959, 263 pp., \$4.50.

Fishbein, Morris, M.D., **THE MODERN FAMILY HEALTH GUIDE**, Doubleday & Company, Inc., Garden City, N. Y., 1959, 1,001 pp., \$7.50.

REVIEWS

Wolstenholme, G. E. W., O.B.E., M.A., M.B., D.Ch., and O'Connor, Maeve, B.A., **CIBA FOUNDATION SYMPOSIUM, CARCINOGENESIS: MECHANISMS OF ACTION**, Little, Brown & Company, Boston, Mass., 1959, 325 pp., 48 illus., \$9.50.

IMMEDIATELY PRIOR TO THE VIIth International Cancer Congress in London in June, 1958, The Ciba Foundation convened a symposium devoted exclusively to carcinogenesis. The participants include the outstanding research workers in this field gathered from all over the world, and the above-titled volume is the collected work presented at this eminent seminar.

The complete work surveys the problem of carcino-

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

genesis from every conceivable aspect (to date) including chemical, viral, hormonal, immunological, pharmacological, radiological, and metallic with all the various ramifications of each.

Basically, the work takes the form of formal presentation of research papers by the various distinguished authorities, and, as is so often true, the "real meat of this sandwich" is found in the unabridged discussions which follow each presentation. Here the reader is "brought up to date" (June 26, 1958) on these various and different yet apparently interrelated factors involved in carcinogenesis.

These authors are speaking with their peers, and this volume must not be considered either an encyclopedia of the subject or an introductory text; indeed, it is most assuredly the acme of advancement in our knowledge of carcinogenesis.

Neil G. Perkinson, M.D.

Mescham, Isadore, M.A., M.D., **AN ATLAS OF NORMAL RADIOGRAPHIC ANATOMY**, W. B. Saunders Company, Philadelphia, Pa., 1959, 759 pp.

THIS 759 PAGE BOOK covers the entire field of radiologic anatomy. Through numerous illustrations, the main anatomical landmarks in radiographs are illustrated. Many of the special procedures in X-ray are covered. A chapter is devoted to the fundamental background for radiologic anatomy. All in all, this is a book which should be at the finger tips of all physicians who do any X-ray work.

Ted F. Leigh, M.D.

Weil, Paul G., B.A., M.D.C.M., M.Sc., Ph.D., **THE PLASMA PROTEINS**, J. B. Lippincott Company, Philadelphia, Pa., 1959, 133 pp., \$3.50.

THIS MONOGRAPH OF 122 pages presents a concise summary of current knowledge about plasma protein and clinical conditions in which the plasma proteins are altered. Each protein fraction is discussed separately and the diseases in which this fraction is altered is discussed in the chapter.

The book is well written and easy to read. The chapter

PHYSICIAN'S BOOKSHELF / Continued

on plasma protein (substitutes) is by far the weakest in the book and might give the unwary reader a biased approach to this field of therapy.

The book should be useful as a short review of this subject for the medical student, the technician, and the clinician who has not been able to keep up with the field. However, its chief value resides as a simple review of the subject and it could not be considered as worthwhile reading for the physician experienced in the clinical problems in which abnormalities of the serum proteins exist.

Walter Lyon Bloom, M.D.

Wolstenholme, G.E.W., O.B.E., M.A., B.Ch. and O'Connor, Cecilia M., B.Sc., CIBA FOUNDATION SYMPOSIUM—REGULATION OF CELL METABOLISM, Little, Brown & Company, Boston, Mass., 1959, 387 pp., \$9.50.

ADDITIONS TO THESE well known symposia are always welcome for the matters are authoritatively treated and the informal discussions are published verbatim. This is a fascinating glimpse into the future but probably will be too technical for the average clinician. The contributors are concerned not only with the function of individual cells but with the functions of such various intracellular structures as the mitochondria, the inclusion bodies, and the endoplasmic reticulum. To the non-chemist these achievements seem like technical miracles; one is astonished at the amount of detailed information available concerning the kinetics of various enzyme systems. Chapters are devoted to the meaning of intracellular structure for metabolic regulation, the topographical aspects of cell metabolism, the control of the rate of intracellular respiration, the quantitative aspects of oxygen utilization, the oxidative pathways of carbohydrate metabolism, the mechanism of glycogen synthesis in muscle, alternative pathways of electron transport, the metabolism of various tumors, and the enzymatic processes of various microorganisms. There is an introduction by Sir Hans Krebs.

Thomas Findley, M.D.

McLaughlin, Harrison L., M.D., TRAUMA, W. B. Saunders Co., 1959, 757 pp.

THIS BOOK IS EDITED by Dr. McLaughlin, Professor of Clinical Orthopedic Surgery, Columbia University, and there are 20 other contributors. It is very well divided into five parts, namely: The Upper Extremity, The Lower Extremity, The Trunk, The Head, and The Special Senses. By this division one can easily find his subject matter when using it as a reference book or desiring to review any particular region or related injury. The style of writing is easy to read and to grasp the problem at hand.

The first portion of the book deals with general considerations, discussing the response to injury, mechanism, repair, and the treatments of infection, vascular injuries, and other such traumatic injuries of a general nature, as most trauma involves fractures. There is considerable discussion on the treatment of fractures.

The other chapters deal with a specific region and injuries that are regional, such as Part II, which deals with the upper extremity, discusses the injuries of the hand, wrist, forearm, elbow, shoulders, and arms. The part on lower extremities discusses injuries of the foot, ankle, leg, knee, thigh, and hip. Part IV, or The Trunk, is divided into injuries of the pelvis, the abdomen, chest, vertebral column, the cervical cord, and the adnexa, along with a very good discussion of the low back

injuries. There is one section on the intervertebral disc and another discussion of low back pain due to other than intervertebral disc injuries.

The final section is divided into the head and special senses, in which injuries of the skull and brain are discussed in detail. There is also a discussion of the auditory apparatus, nose, paranasal sinuses, larynx, and trachea, along with maxillofacial injuries including fractures of the mandible and facial bones. The final chapter is on the injuries of the eye.

This book would be valuable to anyone who has to deal with trauma and the deleterious effects of trauma upon the human body. It can be recommended for present up-to-date treatment of traumatic injuries.

Milford B. Hatcher, M.D.

Pugh, Herbert Lamont, (M.C. Ret.), NAVY SURGEON, J. B. Lippincott Co., Philadelphia, Pa., 1959, 459 pp., \$5.00.

AN AUTOBIOGRAPHY IS a subtle means to toot one's horn or give oneself a friendly pat on the back.

Rear Admiral Lamont Pugh (M.C.) USN (Ret.), Surgeon General of the US Naval Medical Corps, 1951-55, has given a rather detailed account of his entire life, to date, with particular emphasis on his years with the Navy Medical Corps. However, the most interesting part of the book proved to be that which recounted in detail, his boyhood in rural Virginia. This was found to be folksy, true to life, and humorous.

The remainder of the book is a rather dreary travelogue which takes the reader with tedious detail retracing around the world and to far flung US Naval installations. The "yarn" as a sailor would say, is unmodulating except for an occasional highlight of detail in observation of the passing scenes.

The final chapters are given to philosophical meandering. It shows the author to be a man truly wed to military way of life. He rose rapidly to the pinnacle of the Naval Medical Corps and in this rarified atmosphere presumes to compare advantages and disadvantages of the life of a practitioner of medicine in the Military to that of one in private practice. He makes a broad indictment of the private practice of medicine, intimating that by having a Naval career he has escaped or been immune to the retardation of advancement by jealous elders, to the consideration of remuneration for the practice of medicine, to the competition of contemporaries, etc.

To those readers of this book who have practiced both in the Navy and in private life, these views, considering the source, will seem surprisingly naive. In truth it draws attention to the cloistered life, medically speaking, of the Military physician. This book will not send a tidal wave to the literary shore, but could be of interest to those having careers that have intersected this story somewhere along its course.

John H. Ridley, M.D.

Burwell, C. Sidney, M.D. and Metcalfe, James, M.D., HEART DISEASE AND PREGNANCY, Little, Brown and Co., Boston, Mass., 1958, 338 pp., \$10.00.

THIS BOOK CONSISTS of 16 chapters dealing with the clinical aspects of heart disease in pregnancy. Each chapter contains diagrams, tables, and an excellent summary. Emphasis is placed on the physiological approach throughout, so that the management of these patients may be rational rather than empirical. Much use is made of statistical analysis of various series of cases in drawing conclusions as to prognosis and man-

agement. A large proportion of the book is a review of the extensive literature.

Chapters of particular interest and value are: "Maternal Adjustment to Pregnancy," "The Diagnosis of Heart Disease in Pregnant Women," and "The Management of the Pregnant Patient with Heart Disease." Most space is devoted to rheumatic and congenital lesions. The authors offer few personal opinions based upon experience with other varieties. Of 277 cases over a six-year period at the Boston Lying-In Hospital, 236 had rheumatic, 35 had congenital, only two had hypertensive heart disease, and only four had "other types."

The authors are most conservative in their approach to therapeutic abortions, sterilizations, and contraindications to pregnancy. Other authorities would undoubtedly disagree with some of their conclusions. One receives the impression that these patients present no great problem as long as they receive good medical care, since the maternal risk is only about one per cent. The authors state that "it is our current position (from which we are prepared to retreat occasionally) that any cardiac patient is entitled to a trial of pregnancy"; they later reveal that only one out of two pregnancies in their functional class IV patients produced a live infant. They also state that "successful negotiation of pregnancy is possible for almost all patients with heart disease" but point out elsewhere that the risk is appreciably greater in patients with functionally severe heart disease and/or atrial fibrillation. They do not ordinarily advocate corrective heart surgery during pregnancy. They state that "interruption of pregnancy, always a poor solution, is now seldom employed." In the chapter on hypertensive heart disease and eclampsia, the use of ganglionic blocking agents and parenteral reserpine is not mentioned.

In general this book should prove valuable to the interested teacher, some internists and obstetricians, and can certainly be recommended to them. It is not an easy reference for the busy practitioner seeking clear cut advice.

Gordon E. Walters, M.D.

Hilleboe, Herman E., M.D. and Larimore, Granville W., M.D., PREVENTIVE MEDICINE, W. B. Saunders Co., Philadelphia, Pa., 1959, 731 pp.

THE CONCEPT OF PREVENTIVE medicine is an ever-changing one and the field of prevention is constantly expanding as new knowledge becomes available. An enlarged concept is presented in this book which is concerned not only with preventing the occurrence of disease but, also, with preventing its progression.

The section which is devoted to disease prevention deals not only with the control of environmental factors and the prevention of communicable diseases but, also, includes chapters dealing with nutrition, obesity, maternity, and dental health.

The section which is concerned with preventing the progression of disease includes chapters dealing with periodic health examinations, alcoholism, narcotic addiction, rehabilitation, and the early detection and care of such diseases as tuberculosis, cancer, heart disease, and diabetes mellitus.

A third section discusses health education, epidemiologic methods, social services, official and voluntary health agencies, and the role of the hospital in preventive medicine.

This book is essentially a publication of the New York State Health Department. It was written primarily to

serve as a guide to the physician who wishes to include preventive medicine as an integral part of his day by day practice.

T. F. Sellers, M.D.

Cecil, Russell L., M.D., Sc.D., and Loeb, Robert F., M.D., Sc.D., D.Hon.Causa., LL.D., THE TEXTBOOK OF MEDICINE, W. B. Saunders Company, Philadelphia, Pa., 1959, 1,660 pp., index.

THIS TENTH EDITION of a well known and honored text and reference book is an improvement. There is included 37 additional articles of information, but by the use of some minor changes in format and an improved type, no additional bulk has been added to the book.

The basic organization of the material is the same as with the last two or three editions, but more pathological physiology has been included in general with the clinical discussion. This should be particularly helpful to the student of medicine both undergraduate and postgraduate.

The contributing authors are people of recognized ability and reputation in their respective fields. Of special value, it seems to me, is a short but interesting treatise in the foreword on patient physician communication, which, if studied and applied by all students of medicine, will materially improve the quality and accuracy of their diagnostic and therapeutic skills.

Finally, it should be noted that the index of 81 pages has been improved and expanded over that of the last edition. This enhances its value as a reference for the busy practitioner.

This text would be a useful addition to the library of any physician.

J. W. Chambers, M.D.

Moyer, John H., M.D., HYPERTENSION, W. B. Saunders Company, Philadelphia, Pa., 1959, 790 pp.

BOOKS ON HIGH BLOOD pressure appear nearly as fast as new drugs are proposed for treating this ubiquitous disease. A remarkable and praiseworthy feature of this book is the rapidity with which it was edited and published, actually within six months after the symposium was held in Philadelphia in December 1958. It is really current and up to date, especially with regard to treatment. Dr. Moyer has done an excellent job in assembling the 91 participants representing most of the major clinical research workers in hypertension in the United States, and the resulting collection of 80 papers covers nearly every aspect of the pathology, etiology, and medical and surgical treatment of hypertensive disease.

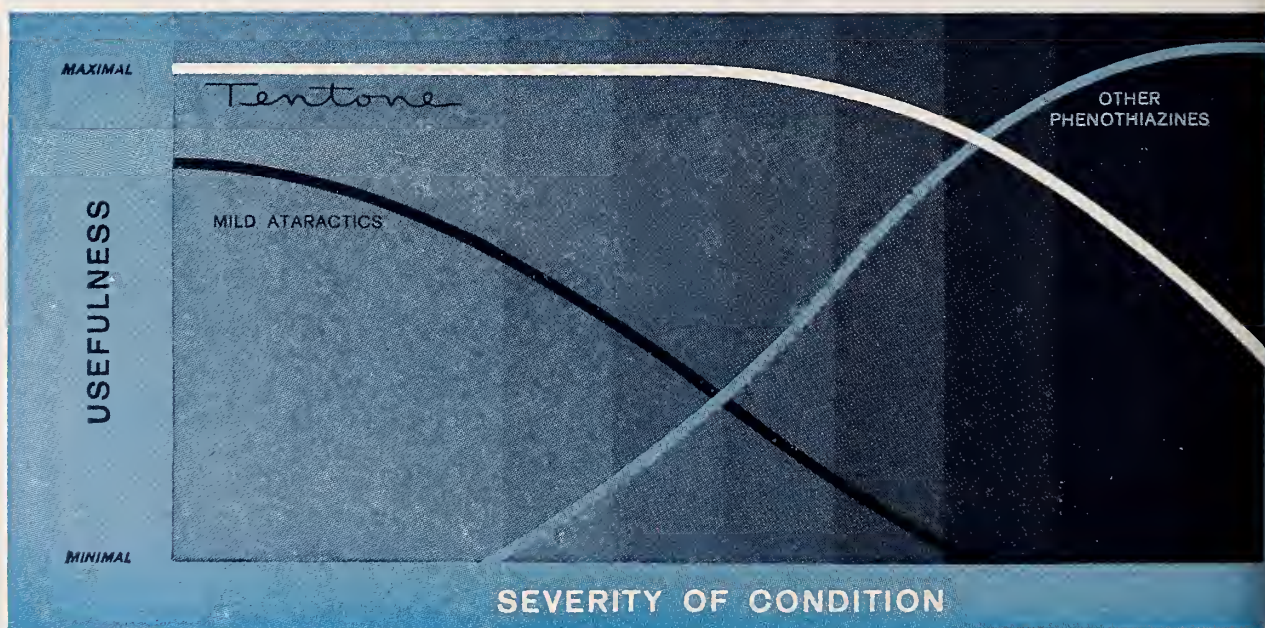
A few of the new or knotty aspects of hypertension that are discussed are as follows: racial susceptibility, the role of pyelonephritis, high pressure as a primary cause of the vascular lesions, cardiac output before and during treatment, diagnosis of renal hypertension, monamine oxidase and oxidase inhibitors (Iproniazid), trace metals, renin in renal hypertension, chlorthiazide and hydrochlorthiazide, hypertension in childhood, and splanchnicectomy, sympathectomy, and adrenalectomy.

There are also excellent summaries of the clinical pharmacodynamics and therapeutic use of all the well known drugs, and interesting panel discussions on surgical treatment as well as a combined medical-surgical approach. As Dr. Moyer says, "Therapy is emphasized," and perhaps this indicates the basic defect in hypertension research, too much therapy and not enough curiosity about fundamental pathophysiology.

Joseph A. Wilber, M.D.

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◆ Positive, rapid calming effect in mild and moderate cases.
◆ Striking freedom from organic toxicity, intolerance, or sensitivity reaction—particularly at low dosage. ◆ Greater freedom from induced depression or drug habituation. ◆ May be useful, as with other tranquilizers, to potentiate action of analgesics, sedatives, narcotics. ◆ Facilitates management of surgical, obstetric, and other hospitalized patients. ◆ Indicated when more than a mild sedative effect is desired...and less than psychosis is involved. ◆ Dosage range: *In mild to moderate cases:* from 30 to 100 mg. daily. *In moderate to severe cases:* from 75 to 500 mg. daily.

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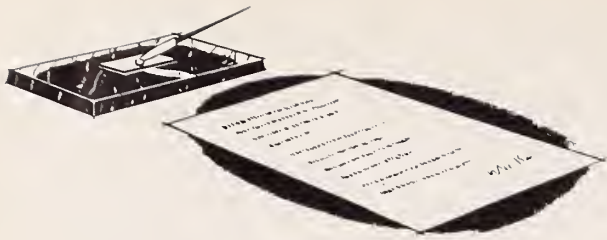
10 mg. tablets



25 mg. tablets



50 mg. tablets



abstracts by georgia authors

Godwin, John T., M.D., St. Joseph's Infirmary, Ivy Street, Atlanta, Georgia, "Subependymal Glomerate Astrocytoma," *J. Neurosurgery* 16:385-389(July)59.

Two cases of a rarely described subependymal glomerate astrocytoma are reported. The importance of recognition and differentiation of this tumor from the more deeper penetrating type of astrocytoma is emphasized in view of its more favorable anatomical localization and possible surgical removal.

Wilkins, Sam A., Jr., M.D., F.A.C.S., Emory Hospital, Atlanta 22, Georgia, and Wills, S. Angier, M.D., Jacksonville, Florida, "The Rectal Bladder for Urinary Diversion," *Surg. Gynec. & Obst.* 109:1-12 (July) 59.

The problem of urinary diversion has become increasingly important with the greater application of extended surgery for various lesions within the pelvis. None of the familiar methods of urinary diversion, including the reservoirs and the conduits, is ideal or always applicable. In searching for a better method and in managing certain particular patients the authors have made use of the isolated rectum as a bladder. Their experience indicates certain advantages in selected patients: The elimination of the use of a plastic bag, the ability to sterilize the rectum being used as a bladder, and certain technical advantages. Ordinarily the patient with a rectal bladder has fairly satisfactory voluntary control of the urine and can manage a dry colostomy simply.

The authors feel the rectal bladder represents another method of urinary diversion which, with the exception of the need for a dry colostomy has no more disadvantages than the short segment substitutes draining to the skin and has certain advantages over them.

Whitley, Milton E., M.D., Emory Hospital, Atlanta 22, Georgia, "Surgical Management in Complications of Diverticulitis of Colon," *Am. Surgeon* 25:386-392 (June) 59.

There are seven complications of diverticulitis for which surgery is indicated. These are perforation, with abscess formation; perforation with generalized peritonitis; presence of a fistula; obstruction; hemorrhage; recurrent severe diverticulitis; and inability to differentiate diverticulitis from carcinoma.

The surgical management of these

complications may be carried out in one, two, or three stages, as sound surgical principles dictate.

Stage 1. Proximal colostomy using right half of the transverse colon. Drainage of an abscess or perforation may also be done at this time.

Stage 2. Resection of the diseased areas of the colon with end-to-end anastomosis.

Stage 3. Closure of colostomy.

Perforation of a diverticulum with peridiverticular abscess or with generalized peritonitis may be encountered when laparotomy is performed with a pre-operative diagnosis of ruptured appendix or ruptured duodenal ulcer. Under these circumstances the area of perforation should be drained through a stab wound and a right transverse colostomy performed. No attempt at closure of the perforation or resection of the colon should be made at this time.

Recent advances in the field of antibiotics and chemotherapeutics may shorten the intervals between stages; however, the sound and proved principles of colon surgery cannot be ignored. It is felt that proper staging of procedures will result in a decreasing incidence of morbidity and mortality.

Rumble, Lester, Jr., M.D., and Bickers, Donald S., M.D., St. Joseph's Infirmary, Ivy Street, Atlanta, Georgia, "Anesthesia for Cortical Excision in Focal Seizures," *South. M.J.* 52:839-844(July)59.

Over the years cortical excision for control of focal seizures in epileptics has been done under local anesthesia. The major reason for performing this operation, uncomfortable though it may be, under local anesthesia was the fact that cortical recordings with the electroencephalogram could be used to locate the site of the epileptogenic focus.

In recent years, with the advent of muscle relaxants, it has become possible to maintain very light planes of general anesthesia. With a previously developed technique utilizing controlled respiration with 75 per cent nitrous oxide and 25 per cent oxygen, it has been possible to successfully perform an operation of cortical excision in a

number of patients. This article presents two of these cases in detail, including their electroencephalographic patterns both pre-operatively, during operation, and following operation.

It is felt in selected cases, particularly in young adults and children, it is possible to offer the patient the advantage of general anesthesia for a rather prolonged and involved procedure.

Whisnant, C. L., Jr., M.D.; Owings, R. H., M.S.; Cantrell, C. G., M.D.; and Cooper, G. R., Ph.D., M.D., (P.O. Box 185), Chamblee, Georgia, "Primary Idiopathic Myoglobinuria in a Negro Female: Its Implications and a New Method of Laboratory Diagnosis," *Ann. Int. Med.* 51:141-150(Aug)59.

The problem of the diagnosis of primary myoglobinuria in a 24 year old Negro female is presented. Discussion of the inadequacy of the spectrophotometer and ultracentrifuge is given. A new, better, and less complicated procedure using paper electrophoresis is described. Paper electrophoresis is performed using 200 volts for 22 hours using Whatman No. 3 filter paper in pH 8.6 barbital buffer of 0.05 ionic strength. The urine specimen for electrophoresis is prepared by adding one part of a benzidine-positive urine to two parts of a human serum. The serum proteins do not stain with benzidine, but they do prevent myoglobin or hemoglobin from adsorbing to the filter paper. Serum specimens from patients suspected of having myoglobinuria are examined directly. After electrophoresis the filter paper is removed from the instrument and fixed in the oven at 125° C. for 10 minutes. Stained patterns are obtained by applying a benzidine-hydrogen peroxide solution with a fine caliber glass hand spray. Since only myoglobin and hemoglobin are stained, and myoglobin migrates only half the distance traveled by hemoglobin, definite differentiation and identification are possible. Photography of the stained pattern must be done immediately because decolorization is fairly rapid.

The benzidine-hydrogen peroxide solution is prepared by dissolving 0.3 gm. of recrystallized benzidine in 2 ml. of glacial acetic acid. Two milliliters of three per cent hydrogen peroxide are added to the benzidine acetic acid mix-

ture immediately before it is used.

The frequency of renal complication in primary myoglobinuria is discussed and emphasized. Speculation regarding the etiology of primary myoglobinuria is reviewed and it is suggested that genes and deficient enzymes may be involved in this disease.

Leigh, Ted F.; Corley, Charles C., Jr.; Huguley, Charles M., Jr.; and Rogers, James V., Jr., Emory Hospital, Atlanta 22, Georgia, "Myelofibrosis," Am. J. Roentgenol. 82:183-193(Aug)59.

The authors present the clinical and radiologic findings in 25 proven cases of myelofibrosis seen at Emory University during recent years. The etiology,

pathogenesis, and pathology of this condition are discussed in detail. The main clinical findings at the time of diagnosis include splenomegaly, hepatomegaly, pallor, purpura, lymphadenopathy, and bone tenderness. The predominant complications of the disease include abnormal bleeding, hemolysis, splenic infarction, infection, and chronic myelocytic leukemia. X-ray examination is important for the identification of myelosclerosis, splenomegaly, and hepatomegaly. In approximately one-half of all cases of myelofibrosis, myelosclerosis is evident.

Crevasse, Lamar E., M.D., Gainesville, Florida, and Logue, R. Bruce, M.D., F.A.C.P., Emory Hospital, Atlanta 22, Georgia, "Peri-

pheral Neuropathy in Myxedema," Ann. Int. Med. 50:1433-1437 (June) 59.

Peripheral neuropathy manifested by severe lancinating extremity pains and paresthesias occurred in 47 per cent of 65 patients with spontaneous myxedema. It was the presenting and dominant complaint in three patients. It may be the initial manifestation of myxedema and precede other symptoms. Because of anemia pallor and neuropathy, myxedema may be confused with pernicious anemia. It may cause confusion with primary degenerative disease of the central nervous system, nerve root compression or hysteria. The neuropathy is completely reversible by adequate thyroid replacement.

INSTITUTE OF STAPHYLOCOCCUS BACTERIOLOGY

The Fulton County Medical Society (Committee on Infections), and the Communicable Disease Center (U. S. Public Health Service) are sponsoring a one day Institute on Staphylococcus Bacteriology.

The Objectives are:

1. Educational
2. Standardization of Methodology
3. Improving Efficiency of Staphylococcus Bacteriology for Clinical and Epidemiological purposes.

ALL PATHOLOGISTS, MEDICAL TECHNOLOGISTS, AND BACTERIOLOGISTS ARE INVITED TO PARTICIPATE. If the number of applicants is large, a second Institute may be necessary.

The Institute will be held on *Saturday, December 5, 1959 from 8:00 A.M. Sharp til 1:00 P.M.*

Registration 7:30 A.M.

Academy of Medicine

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DR. VENABLE TO FOLLOW DR. SELLERS AS STATE HEALTH DIRECTOR

DR. THOMAS F. SELLERS, director of the Georgia Department of Public Health, who will retire at the end of December after 47 years of public health work in Georgia, will be succeeded January 1 by Dr. John Venable, present assistant to Dr. Sellers and director of Milledgeville State Hospital.

The new appointment was announced by Dr. Fred Simonton of Chickamauga, chairman of the State Board of Health, which was unanimous in its selection of Dr. Venable. Salary of the director is \$15,000. Dr. Sellers will remain with the Department as director-emeritus. The term of the new director is six years.

Following arrival at Milledgeville later this month of Dr. Irville Herbert MacKinnon of Columbia University as new superintendent, Dr. Venable will retain his position as director with offices in Atlanta.

"Dr. Sellers has had a long and outstanding record of public health service in Georgia," Dr. Simonton said. "He has been director of the Department during a time of tremendous growth and development of public health. The State Board of Health has

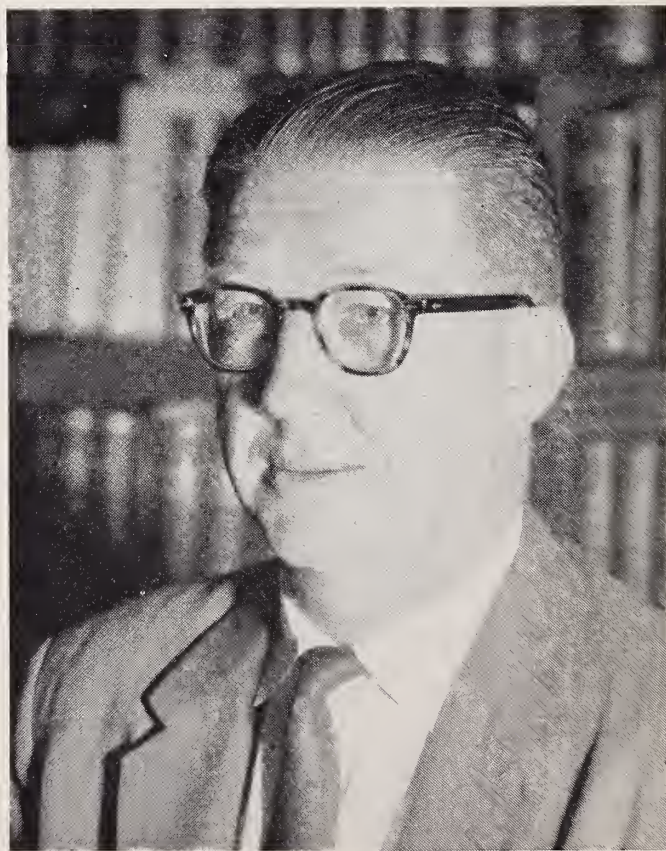
always found him to be a trusted and efficient public servant.

"We have selected Dr. Venable because of his experience and qualifications and his familiarity with the public health program in Georgia. He has recently given additional proof of his ability to deal with highly complex administrative problems as acting director of the Milledgeville State Hospital. We feel that the people of Georgia will greatly benefit from his service as new State Health Director, as it has in the past with Dr. Sellers. We are particularly proud that in the 56 years of its existence, the Department of Health has only had three directors. Previous directors were Dr. H. F. (Roy) Harris, 1903-1917, and Dr. Thomas F. Abercrombie, 1917-47."

Dr. Sellers, a native of Grand Bay, Alabama, in 1891, began his public health career as bacteriologist for the City of Macon in 1912, after graduation from Mercer University in 1911. He received his M. S. degree from the University of Michigan in 1917, and in the same year became director of laboratories for the Georgia Department of Public Health, re-



Dr. Thomas F. Sellers, Sr.



Dr. John H. Venable

maintaining in that position until becoming director of the Department in 1948. He received his M.D. degree from the Emory University School of Medicine in 1932. During his years with the laboratories, he did considerable research on rabies and published numerous articles on rabies in state, national, and international medical and public health journals.

He was married in 1921 to Miss Mary Amanda Baluss, and has one son, Dr. Thomas Fort Sellers, Jr., a staff member of Emory University School of Medicine who also works at Grady Hospital.

Dr. Venable, is a veteran of many years of varied work in public health. He has been assistant to the director since 1954. He has served both in public health and as a faculty member of the Emory University School of Medicine. Dr. Venable is also director of Special Services, under which are grouped

Battey State Hospital and the Department's Division of Hospital Services and Division of Health Education and Training.

A native of Atlanta, Dr. Venable graduated from the Emory University School of Medicine in 1933. He was a member of Emory medical faculty from 1934 until 1946.

In 1946, he accepted the position of commissioner of health for Whitfield and Murray counties. He became a commissioner of health for Spalding, Pike, and Lamar counties in 1950, and held that position until 1952. He also attended Tulane University and received a graduate degree in public health in 1951.

Dr. Venable has published a number of articles on medical education, anatomy, and embryology, as well as one article on community organization for health.

1959 CALENDAR OF MEETINGS

State

May 1-4, 1960—Annual Session, Medical Association of Georgia, Municipal Auditorium, Columbus.

Oct. 24-25—Georgia Radiological Society, Oglethorpe Hotel, Savannah.

Dec. 1-3—Medical College of Ga. and Medical College of Ga. Foundation's Postgraduate Course, Augusta.

Regional

Nov. 2-5—Twenty-seventh Annual Assembly, Omaha Mid-west Clinical Society, Civic Auditorium, Omaha, Neb.

Nov. 16-19—Southern Medical Association, Atlanta.

National

Nov. 2-6—American College of Physicians, Postgraduate Course No. 3, State Univ. of N. Y. Upstate, Syracuse, N. Y.

Nov. 29-30—American College of Chest Physicians, Dallas, Tex.

Nov. 29-Dec. 2—National Society for Crippled Children and Adults, Chicago, Ill.

Dec. 1-4—AMA Clinical Meeting, Dallas, Texas.

Dec. 5-10—American Academy of Dermatology and Syphilology, Palmer House, Chicago, Ill.

Jan. 11-13—American Academy of Allergy, Hollywood Beach Hotel, Hollywood-by-the-Sea, Fla.

Feb. 3-6—American College of Radiology, Roosevelt Hotel, New Orleans, La.

Mar. 21-24—AAGP, Annual Scientific Assembly, Convention Hall, Philadelphia, Pa.



the association

ANNOUNCEMENTS

New York University-Bellevue Medical Center announces a full-time, three week course, November 30 through December 18, 1959 on Allergy. Morning sessions are devoted to laboratory instruction, while two afternoons a week are spent in the outpatient allergy clinic. Lectures on pediatric allergy, skin allergy, food, mold, drug, and insect allergy are presented. For further information, write: Associate Dean, NYU Post-Graduate Medical School, 550 First Avenue, New York 16, N. Y.

The Tenth annual County Medical Societies Civil Defense Conference will be held in Chicago, November 7-8, 1959, at the Morrison Hotel. Purpose of the conference, sponsored by the AMA's Council on National Defense, is to inform and assist medical and health personnel for their roles in the event of a disaster. Additional information can be obtained by writing: Mr. Frank W. Barton, Secretary, Council on National Defense, AMA, 535 N. Dearborn, Chicago 10, Ill.

American College of Allergists Graduate Instructional Course and Annual Congress, February 28-March 4, 1960, The Americana Hotel, Bal Harbour, Miami Beach, Florida. For information contact: John D. Gillaspie, M.D., Treasurer, 2049 Broadway, Boulder, Colorado.

New York University-Bellevue Medical Center's Post-Graduate Medical School offers a course in Arthritis and Related Disorders for general physicians, November 9-13, 1959, and *again* May 16-20, 1960. This course is planned for the general practitioner who requires a basic knowledge of the field of arthritis and related disorders, including general incidence, classification, differential diagnosis, clinical manifestations, pathologic characteristics, laboratory studies, and treatment. Clinic and bedside teaching will be stressed. For additional information: Office of the Associate Dean, NYU Post-Graduate Medical School, 550 First Ave., New York 16, N. Y.

The Practical Fundamentals of Clinical Electrocardiographic Interpretation, a part-time course of eighteen sessions, November 4, 1959 through March 16, 1960 (excluding December 23 and 30, 1959), designed to

teach not only technical interpretation but to emphasize the clinical significance of the electrocardiogram and *Electrocardiography*, a full-time, five-day course, November 9-14, 1959, dealing with modern electrocardiography and stresses the basic electrophysiology of the heart rather than the pattern diagnosis, will be sponsored by the NYU Post-Graduate Medical School. For further information write: Associate Dean, NYU Post-Graduate Medical School, 550 First Ave., New York 16, N. Y.

DEATHS

CHARLES CRISP BENTON, Macon, was killed instantly in an automobile accident August 22.

A native of Monticello, Dr. Benton was graduated from Emory University and the Medical College of Georgia at Augusta. He came to Macon in 1949 and organized a group of anesthesiologists. He was on the anesthesiology staff of Macon Hospital and practiced anesthesiology at The Clinic, Parkview, and Middle Georgia hospitals.

Dr. Benton was a member of Christ Episcopal Church. He was a Navy veteran of World War II and was recalled for further service as a naval officer during the Korean War.

Survivors include his wife; a son, Charles C. Benton, III; two daughters, Katie and Carden Benton; his parents, Mr. and Mrs. H. O. Cunnard, Atlanta; a brother, Dr. Don B. Benton, Macon; and an aunt Mrs. John B. Branan, Monticello.

WILLIAM MAYES GOBER, who helped found the Kennestone Hospital in Marietta in 1949 and was the hospital's first chief of staff, died September 4 at his country home near Canton at the age of 72.

Before his retirement in 1955, Dr. Gober had practiced medicine in Cobb County for more than 30 years.

He was born in Marietta and attended public schools there before training at the University of Georgia and Johns Hopkins University.

Dr. Gober was a member of the Cobb County Medical Society, Medical Association of Georgia, and the American Medical Association, and an honorary staff member of Kennestone Hospital.

Survivors include his wife; a son, William Mayes

Gober, Jr., Moorehaven, Fla.; two daughters, Mrs. Richard Starke, Jr., Smyrna and Miss Sally Gober, Canton; a brother, T. A. Gober, Clarkston; and five sisters, Misses Gladys and Alice Gober both of Marietta, Mrs. A. G. Conoley, Mrs. N. B. Browne, and Mrs. W. H. Steele, all of Atlanta.

MAUDE ELIZABETH FOSTER, 75, of Atlanta, died July 30 after an extensive illness.

She was the daughter of the late J. Z. Foster and Mrs. Anna Durham, pioneer citizens of Cobb County and Marietta. Her father was a prominent attorney in Marietta for a number of years.

Dr. Foster was born in Cobb County and since 1914 had been a practicing physician in Atlanta.

HENRY BRUCE JACKSON, 74, passed away at the Newnan Hospital on July 28. He was a physician in the Welcome Community of Coweta County.

Dr. Jackson was born and reared in Coweta County and had lived his entire life there. He was a 1909 graduate of the Old Atlanta School of Medicine, now Emory University School of Medicine, and was one of the state's oldest practicing physicians. He was a member of the Medical Association of Georgia and the American Medical Association.

Survivors include his wife; one daughter, Mrs. R. L. Wilson, Franklin; five sons, J. C. Jackson, Fred Jackson, Q. M. Jackson, all of Newnan, Emmett Jackson, Franklin, and Joe P. Jackson, Conyers; one sister, Mrs. H. L. Taylor, Franklin; 12 grandchildren; and one great grandchild.

J. PHINIZY HITCHCOCK of Augusta died August 7, in an Augusta Hospital at the age of 48.

Dr. Hitchcock was graduated from the Medical College of Georgia. After graduation he began practice in Augusta and made his home there until his death. He was an active member of the Augusta First Baptist Church.

Survivors include his wife; mother; two daughters, Miss Ginger Hitchcock, Wheaton College in Illinois and Miss Emily Hitchcock, Augusta; one son, J. Phinzy Hitchcock, Jr., Augusta; three sisters, Mrs. M. B. Sell, Augusta, Mrs. E. G. Bentley and Mrs. M. K. Johnson, of Dallas; and two brothers, W. E. Hitchcock, Sandusky, Ohio and Ed Hitchcock, Greensboro, N. C.

PERSONALS

First District

CURTIS G. HAMES and L. H. GRIFFIN of Claxton are taking part in a research project in Evans County designed to help solve some of the puzzles of heart attacks.

Second District

Recently WILLIAM L. BRIDGES, JR., Tifton, was certified as a diplomat of the American Board of Pediatrics.

PAYTON ELLIOTT BELL, retired physician and druggist of Sylvester, recently celebrated his 91st birthday.

Third District

Receiving commendation for their "unselfish support" of the Columbus Heart Clinic for the past year from a special committee representing the Georgia Heart Association were G. BERTLING SMITH, W. P. RIVERS, JR., A. J. KRAVTIN, SIMONE BROCATO, HAYWOOD TURNER, RALPH E. TILLER, CLARENCE BUTLER, HARRY H. BRILL, and JACK HIRSCH.

Fourth District

JAMES H. ARNOLD, Newnan, has been selected to fill a vacancy on the Coweta County Hospital Authority.

A special committee representing the Georgia Heart Association commended CURRAN S. EASLEY, W. B. FACKLER, CECIL MAJOR, J. W. CHAMBERS, E. W. MOLYNEAUX, ROBERT W. WEST, and J. R. TURNER for their "unselfish support" of the LaGrange Heart Clinic during the past year.

Fifth District

R. C. WILLIAMS of Atlanta outlined steps necessary for Butts County to take to obtain a 25 bed Hill-Burton Hospital at a meeting of the Jackson Kiwanis Club recently.

JOHN E. BECK of Decatur has announced that he was giving up private practice to accept a position as regional medical director for Pfizer Laboratories in New York City.

JAMES H. BYRAM and McCLAREN JOHNSON, Atlanta, have recently been named chairman and vice-chairman respectively, of the 53rd annual Southern Medical Association conference which will be held in Atlanta in November.

RHODES HAVERTY of Atlanta was a guest lecturer recently for the regular meeting of the Atlanta Chapter, National Cystic Fibrosis Research Foundation.

T. W. SELLERS, Atlanta, gave the principal address at the dedicatory services for the Kennestone Hospital Addition at Marietta last month.

Sixth District

Recently C. STERLING JERNIGAN completed 62 years of medical practice in Sparta and Hancock County.

Seventh District

DR. AND MRS. LUKE GARRETT of Austell recently returned from a fishing trip to Mayport, Florida.

Eighth District

The Hazlehurst Kiwanis Club paid special tribute to C. R. YOUMANS, who will soon be moving to St. Simons Island.

E. C. KANE, J. A. HIGHTOWER, H. L. MOORE, W. F. AUSTIN, W. O. INMAN, E. R. JENNINGS, B. A. ADDISON, and J. L. HUNT were commended by a committee representing the Georgia Heart Association for their "unselfish support" of the Brunswick Heart Clinic this past year.

ARTHUR M. KNIGHT, JR. of Waycross showed a film and spoke on "strokes" to the Waycross Rotary Club recently.

Ninth District

C. C. BROOKS of Blue Ridge has moved to Atlanta. HOWARD HUENERGARDT, formerly of Ellijay,

has moved to Dalton and is associated with EARL T. McGHEE.

CHARLES H. LITTLE and GEORGE D. GOWDER, JR. have opened a new clinic in Blairsville.

THOMAS J. HICKS has built a modern clinic in McCaysville.

W. T. ARIAIL of Cornelia, attended the meeting of the Southern Endocrinology Society at the Talmadge Memorial Hospital in Augusta recently. Dr. Ariail, a past president, was elected to serve as vice-president for the coming year.

W. BRUCE SCHAEFER, Toccoa, spoke to the Northeast Georgia Hospital Administrators' Association in Cornelia recently.

Tenth District

ROBERT G. ELLISON of Augusta spoke to the Public Health Nurses and Doctors of the Seventh District of the State Health Department in Statesboro last month.

J. H. NICHOLSON, W. C. McGEARY, JR., and E. R. LEVERETT have been elected officers of the newly formed Medical Staff of Morgan Memorial Hospital.

CORBETT H. THIGPEN, Augusta, spoke to the Macon Kiwanis Club on hypnosis therapy at one of their recent meetings.

SOCIETIES

The FULTON COUNTY MEDICAL SOCIETY'S Traffic Safety Committee has received an initial donation of \$4,000 toward its goal of about \$38,500 for its study of the health of traffic offenders.

A well-known Florida thoracic surgeon, J. Brooks Brown of Jacksonville, was principal speaker at a recent WARE COUNTY MEDICAL SOCIETY meeting.

SCHOOL CHILD HEALTH COMMITTEE

THE 1959-1960 MAG COMMITTEE on School Child Health was called to order at 7:45 P.M., Thursday, August 13 at the Heart of Atlanta Motel, Atlanta, Georgia.

Present in addition to Chairman Grady Black of Griffin were Robert N. Poole, Atlanta; M. D. Pittard, Toccoa; William H. Bonner, Athens; and Virginia McNamara, Atlanta. Also present was Mr. John F. Kiser of the MAG Headquarters Office.

Chairman Black and others reviewed past activity of the Committee, including activities of other state School Health Committees.

Following discussion, the Committee adopted the following statement of basic aims and purposes:

- "Primary general functions of the MAG Committee on School Health shall be to:
- (1) Stimulate cooperation by individual physicians in the school health program;
 - (2) Keep the profession informed on school health problems;
 - (3) Encourage sanction by the medical profession of a sound school health program;

- (4) Report to the profession on progress; and
- (5) Cooperate in developing school health programs with the Health Department, school systems, dental societies, parent groups, and other appropriate organizations."

HEALTH, SAFETY, AND PHYSICAL EDUCATION IN GRADES 7 TO 12

The Committee discussed various aspects of health and safety and physical education in high schools. It was generally agreed that the Committee recommends that all students in grades 7 to 12 receive the minimum of 30 minutes daily of supervised calisthenics. Statistics in the AMA Journal were cited and it was suggested that further investigation of work be done in this area with Dr. Pittard as Chairman of a Sub-Committee on this subject. It was also generally agreed that the Committee should recommend that all physicians cooperate with physical and health education programs and work with the directors of these programs, particularly in regard to advising parents, etc. It was suggested that county societies maintain lists of physicians willing to talk to school groups on medical and related subjects.

DRIVER TRAINING

It was felt by the members of the Committee that driver training should be required in all high schools in Georgia. It was felt that the MAG Committee on School Child Health could be very helpful to a driver training program in an advisory capacity. This Sub-Committee was assigned to Dr. Black.

SCHOOL BUS SAFETY

Dr. McNamara described the school bus program in Georgia and stated that approximately 425,000 children ride buses to school daily in Georgia. She stated that the State Department of Education now promulgates rules and regulations for health screening for drivers, but it is up to the local school system as to whether or not these are carried out. The Committee authorized Dr. McNamara to send a letter after approval by Chairman Grady Black, to the proper state authorities expressing the interest of the Committee in the field of school bus safety. This subject and Sub-Committee was assigned to Dr. McNamara.

ATHLETIC INJURY

The Committee discussed the possibility of revising the athletic examination form for sport participation. The Committee expressed an interest in organizing a state-wide conference for physicians and coaches on athletic injury and Dr. McNamara and Mr. Kiser were instructed to look into this possibility. The subject of athletic injury was assigned to Dr. Bonner as Chairman of this Sub-Committee. It was generally agreed that a letter would be sent to the secretaries of all county societies requesting that they appoint a physician to serve at all athletic games. It was also suggested that Dr. McNamara notify the Department of Education of the Committee's interest in this area.

VISION AND HEARING SCREENING

Dr. McNamara discussed the program of the Health and Education Department in regard to vision and hearing screening. It was suggested that a questionnaire be mailed to all county societies to open their eyes as to what is being done and what isn't being done in their own community. It was suggested that this questionnaire cover the entire area of school child health in an effort to encourage physicians on the local level to take a more active interest in school child health.

IMMUNIZATION

Dr. Poole was assigned the subject of Immunization and will investigate this area further and report at the next meeting.

Dr. Black reported that he is planning to attend the 7th National Conference on Physicians and Schools, Highland Park, Ill., October 13-15, 1959 and Dr. McNamara will also be in attendance representing the Georgia Department of Public Health.

The next meeting of the Committee was tentatively set for 6:30 P.M., Thursday, October 29. There being no further business the meeting was adjourned.

ADVISORY COMMITTEE FOR MEDICAL LABORATORY ASSISTANTS TRAINING COURSE

THE MEETING OF THE Advisory Committee to the Medical Laboratory Assistants Training Course was called to order by Albert Morris at 11:10 A.M., August 9, 1959 in the Administration Build-

ing of the North Georgia Trade and Vocational School, Clarksville, Georgia.

Members of the Committee present include: Albert L. Morris, M.D., Fairburn, Medical Association of Georgia; Sister Andrew Josephine, M.T. (ASCP), Augusta, Georgia Society of Medical Technologists; Mr. Millard Wear, Marietta, Georgia Hospital Association; Miss Pattisue Jackson, Atlanta, Laboratory Consultant, Division of Hospital Services, State Department of Public Health; John Godwin, M.D., Atlanta, Georgia Association of Pathologists; and Mr. H. O. Carlton, Director, North Georgia Trade and Vocational School and discussed the purpose, scope,

Guests at this meeting included: Mr. Glenn Hogan, Atlanta, Georgia Hospital Association; Mr. M. D. Krueger, Atlanta, Medical Association of Georgia.

Mr. H. O. Carlton gave the background of the North Georgia Trade and Vocational School and discussed the purpose, scope, and the authority of the Advisory Committee. General discussion then ensued about the relationship of Medical Laboratory Assistants to ASCP Registered Technologists.

CURRICULUM

By general agreement and after discussion the following curriculum for the course of study for medical laboratory assistants was approved. This curriculum is as follows:

- (1) Professional Ethics
- (2) Terminology and Medical Spelling
- (3) Keeping records and reports
- (4) Care and Maintenance of all types of Laboratory equipment
- (5) Elementary Anatomy and Physiology
- (6) Basic Chemistry to include working solutions
- (7) Urinalysis to include the following procedures:
 - (a) Albumin
 - (b) Sugar
 - (c) Microscopic
 - (d) Specific gravity
 - (e) PH Determination
 - (f) Acetone
 - (g) Bile
 - (h) Urobilinogen
 - (i) Occult Blood
 - (j) Physical characteristics of Urine Specimens
- (8) Blood chemistry to include the following tests:
 - (a) Sugar
 - (b) NPN and/or BUN
 - (c) Urea
 - (d) Bilirubin
 - (e) Icterus Index (Explain)
 - (f) Chlorides
 - (g) CO₂
- (9) Hematology to include the following procedures:
 - (a) WBC
 - (b) RBC
 - (c) Hemoglobin
 - (d) Hematocrit
 - (e) Sed. Rates
 - (f) Bleeding and Clotting time
 - (g) Blood smears (basic, cellular morphology which must be checked by Doctor of Medicine if atypical cell)
- (10) Prothrombin Time (With Caution)
- (11) Serology and Blood Banking
 - (a) Typing, RH, and cross matches (must be checked by a Doctor of Medicine) and Coombs Tests to include the minimum safe procedures recommended by the American Blood Banking Association.
 - (b) VDRL
- (12) Preparation of specimen for mailing to larger laboratories to include:
Pathological tissues and cytological preparations (fixatives)
- (13) Spinal Fluids to include the following:
 - (a) Cell count
 - (b) Sugar
 - (c) Pandy
 - (d) Physical characteristics and Specific gravity of fluid
 - (e) Colloidal gold
- (14) Bacteriology, to include the preparation of smears and the staining thereof with grams stain, preparation of cultures, collection of blood cultures, and also the preparation of materials for mailing to larger laboratories for further bacteriological studies. (T.B. smears checked by a Doctor of Medicine should know how to perform coagulase test for staphylococcus).
- (15) Feces studies to include:
 - (a) Occult Blood
 - (b) Preparation of smears and other material for mailing to larger laboratories.
- (16) Gastric Analysis, tubeless type (Diagnex)
- (17) EKG or Electrocardiography

ETHICS

Discussion was held on the subject of the trainees individual ethics and the general ethics of the Health and Medical profession. It was considered by the Advisory Committee that ethics be given due emphasis during the training period. By general agreement Sister Josephine and Miss Jackson agreed to rough draft and submit to the Advisory Committee a model code of ethics based on a modification of the ASCP Guide to Ethics, etc. It was further agreed that this rough draft would be submitted to Mr. Carlton who would mail it to members of the Committee for their consideration.

DEFINITION OF STATUS

By general agreement it was decided that the title of such a trainee taking this proposed course of study would be "Medical Laboratory Assistant".

ADMISSION MECHANISM

After discussion it was agreed that the admission qualifications for students should be as follows:

- (1) High school graduate with chemistry course or its equivalent ranking in the upper third of an accredited high school;
- (2) That the prospective student have a rating in an aptitude test in the 40 percentile or better;
- (3) The applicant have three personal references and a transcript of high school credits;
- (4) That the North Georgia Trade and Vocational School will gather a resume of references and test data and submit this material on each applicant to the Advisory Committee for counsel and guidance.

TRAINING HOSPITALS

By general agreement it was recommended that Mr. Wear and Mr. Hogan submit a list of interested hospitals for the in-training portion of the proposed Medical Laboratory Assistants program. It was further suggested that Mr. Wear and Mr. Hogan work out certain details of the relationship between the school and the hospitals cooperating in this program.

PERFORMANCE CONTROL

In connection with the performance control for Medical Laboratory Assistants, the following recommendations were approved:

- (1) That the in-training performance control is primarily a function of the school and the instructor in the course of training.
- (2) That the medical laboratory assistants after completing such a course of instruction be required to attend annually a post-graduate refresher course to be sponsored by the State Department of Public Health.
- (3) That an evaluation of the performance of the Medical Laboratory Assistants be undertaken by the State Department of Health with the Georgia Association of Pathologists as a further check on the laboratory assistant working in the field. It was recommended that this evaluation be undertaken annually.

Dr. Morris then called for further business and there being none the meeting was adjourned at 3:30 P.M. On motion duly made and seconded the members of the Advisory Committee expressed their sincere appreciation to Mr. H. O. Carlton for his most gracious hospitality on the occasion of this meeting.

EXECUTIVE COMMITTEE OF COUNCIL

IN A PHONE CALL discussion with the members of the Executive Committee of Council of the Medical Association of Georgia on August 12, 1959, the Executive Committee made certain recommendations on the following items of business. Members of the Executive Committee discussing these actions were as follows: Luther H. Wolff, Columbus, President and Chairman of Executive Committee; Milford B. Hatcher, Macon, President-Elect; Chris J. McLoughlin, Atlanta, Secretary; J. G. McDaniel, Atlanta, Council Chairman; and Virgil Williams, Griffin, Finance Committee Chairman.

PROFESSIONAL CONDUCT

A Professional Conduct Report made by Charles Brown, 1st District Councilor and addressed to Luther Wolff was received and it was recommended that this be referred to the Association Professional Conduct Committee.

BUDGET COMMITTEE REPORT

The report of the Finance Committee listing the monthly in-

come and expenditures were received for information.

COMMITTEE EQUIPMENT

The request of the Chairman of the Health Care of the Aging Committee for dictating equipment was taken under advisement. It was recommended that the matter be referred to the October meeting of Council and that the Headquarters Office make available one of its dictaphones for use by the Chairman of this Committee.

COMMITTEE APPOINTMENTS

The Georgia Tuberculosis Association requested an MAG

representative serve on a Georgia Sub-Committee on "Tuberculin Testing in Schools." The State Health Department requested the appointment of a MAG representative to serve on a Poison Control Advisory Committee to the State Department of Public Health. These two appointments were referred to President Wolff for action.

HEADQUARTERS BUILDING PLANNING

Members of the Executive Committee were informed that it would be impossible to visit the new MAG Headquarters Building at the present time and it was agreed that at the next meeting of the Executive Committee, an inspection of the building be held so that plans might be discussed for the future removal of offices from the present Headquarters Office.

DATE AND SITE OF NEXT MEETING

By general agreement the next meeting of the Executive Committee of Council was tentatively set for September 20, 1959 at 10 A.M., MAG Headquarters Office Building, Atlanta.

There being no further business the meeting was then adjourned.

FORAND BILL DEFERRED

CONGRESS THIS YEAR failed to take final action on any legislation of major interest to the medical profession except for the annual appropriation for medical research.

However, work was started on three measures of particular concern to physicians—the Forand, Keogh-Simpson, and international health research bills. Showdown votes on them are probable next year. If they are to be considered further by Congress.

The House Ways and Means Committee held hearings on the Forand bill, but deferred showdown voting on it until next year. The legislation—which is vigorously opposed by the medical profession, other groups on the health team, and the Eisenhower Administration—would provide hospital, surgical, and nursing home care for federal Social Security beneficiaries. Social Security taxes would be raised to help finance the expensive program.

The Keogh-Simpson bill, after being approved by the House, was left hanging in the Senate Finance Committee. The Senate committee held two sets of hearings. It could vote early next year on the legislation which would grant income tax deferrals to physicians and other self-employed persons as an incentive to invest in private pension plans.

Chairman Oren Harris (D., Ark.) postponed until next session a vote by the House Commerce Committee on the Senate-approved international medical research bill because of a backlog of more urgent measures requiring committee action this year. He said that "a diligent effort" would be made during the recess to clarify a number of points at issue revealed in testimony before his committee.

The bill calls for an annual \$50 million authorization to finance a new national institute of health to foster international medical research programs and cooperation. The Administration opposes some of its provisions.

President Eisenhower and Arthur S. Flemming, Sec-

retary of Health, Education, and Welfare, made clear that they didn't feel bound to spend the additional \$106 million which Congress voted for medical research. Congress raised the \$294 million requested by the President to \$400 million.

Mr. Eisenhower expressed concern that Congress is going too fast in providing medical research funds which are administered by the National Institutes of Health. He warned of a danger that the quality of research projects might be lowered and that manpower and other resources might be diverted from "equally vital teaching and medical practice."

He directed that every project approved must be "of such great promise that its deferment would be likely to delay progress in medical discovery."

Secretary Flemming said that the President's criteria would be followed conscientiously. But the Secretary gave assurance that the restrictions would not be so rigid as to hamper research by denying funds for worthwhile projects.

One of the most important and surprising developments during this session of Congress was the political power shown by Mr. Eisenhower, a lameduck Republican president, in generally calling the shots on legislation although Democrats controlled the House and Senate with substantial majorities.

In his fight against "big spending" measures sponsored by Democrats, the President effectively used his veto power to get the bills more to his liking. The Democrats were unable to muster the votes to override vetoes of two housing bills.

A third compromise housing bill retained three provisions of interest to the medical profession. One would provide Federal Housing Administration loan guarantees for building proprietary nursing homes. A second would provide FHA loan guarantees and direct loans for housing for elderly persons. The third would authorize loans for construction of housing for interns and nurses.

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COVER

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TIME FOR MEDICINE'S RE-ENTRY

Louis M. Orr, M.D., *Orlando, Florida*

THE OTHER DAY I came across an interesting remark made by Benjamin Franklin, when he was 31 years old. "I perceive myself to be growing old," he said.

Although he lived to the ripe old age of 84, Franklin had good reasons for that remark. In his day, the average life span was 35 years.

Since that time, however, the life expectancy of Americans has more than doubled, so that a child born today can expect to live into his 70's. Just 10 years ago, that figure was 65.

And the population of persons 65 and over now numbers about 15 million, or one out of every 11 citizens. By 1980, that proportion will have changed to one out of seven.

We can trace the causes for such a lengthened life span to medical progress and improved sanitation. In a sense then, the medical profession shares with its allies in the health field responsibility for more people living longer.

In recent weeks, I have visited several state medical societies, and at each of them I found the subject of greatest importance—a concern for the health care of the aged. What are we doing about this problem, and why are we concerned?

Our so-called enlightened civilization today is engaged in practices that would make former generations blush with shame. When a man celebrates his 65th birthday, in many instances, he is shoved out of active living, whether he wills it or not. Along with his birthday cards, the senior citizen often receives a virtual sentence to perpetual exile by an unthinking society.

Of course, this is not always the case. Many of our senior citizens lead active and rewarding lives.

All physicians are urged to join in the campaign to solve the health care needs of the aged.

But there are those who lose their zest for living because they have nothing to live for. It is this second group I am talking about when I say our society has hung millstones around their necks.

These are the senior citizens for whom we must unbar the gates of misconception. American misunderstanding has erected a wall of falsehood and error around the elderly.

To free the aged, to restore them to the society of the living, we must unlock these gates of misunderstanding, and replace them with truth and realism.

Misconceptions About the Aged

How does America exile its elderly into oblivion? I believe our society has unwittingly allowed six basic misconceptions about the aged to develop.

The *first* is the belief that everyone reaching the age of 65 is washed up, ready to be flunked out of life.

The *second* is that all 15 million of our old people are in urgent need of medical care.

The *third* is that health needs are the only needs of the aged.

Fourth is that American physicians are uninterested in helping the senior citizen.

The *fifth* is that only a federal program can meet the needs of the aged, so we might as well let the government take care of everything.

The *sixth* is that there is nothing new about old age.

MEDICINE'S RE-ENTRY / Orr

Each of these misconceptions is so widespread that we must examine them in greater detail.

1. The fallacy that a man's life is through when he reaches 65 is an ironic one. Its strongest supporters are those who, when they themselves approach advanced age, will vigorously denounce such ideas. Those who have spread such a misconception throughout our nation are the truly misinformed. To them, old age symbolizes decrepitude, senility, and unnecessary burdens on a youthful society. They are the ones who shun the elderly and exiled their aged relatives to charity wards and old people's homes. They would never consider employing a man over 40 because, as they see it, "older men are just less dependable."

Regardless of how absurd such claims sound to us, we must remember they form a major segment of the barricade around our senior citizens. . . . This misconception is the first we must break down in our liberation of the elderly. There is no reason—physical, mental, or social—that advanced years should be the end of the road, particularly in our civilization. History is rich with examples of men who have reached their primes *after* 65.

2. Those who would capitalize on the needs of the aged would have us believe that all 15 million old people in this country are invalids in desperate need of medical care. Such statements are completely refuted by medical science and research. The vast majority of our senior citizens enjoy basically good health.

3. Another serious misconception is that health needs are the only ones facing the aged. On the contrary, our society's ruthless discarding of senior citizens has created a host of additional problems.

The system of compulsory retirement arbitrarily

based on chronological age each year throws thousands out of work, forcing them to live on reduced incomes. This enforced pauperism cripples our senior citizens occupationally, financially, and socially, as well as psychologically.

I believe we have an urgent obligation to correct such harmful actions, and to help our nation understand the many different and unnecessary burdens thrust on the elderly. The American Medical Association's House of Delegates has denounced compulsory retirement, and our Committee on Aging has urged industry and labor leaders to re-evaluate such policies. Certainly in a land which places such emphasis on individual ability, practices of this nature are unrealistic.

4. An often repeated falsehood is that physicians have no interest in the needs of our aging population.

The medical profession's serious concern for our senior citizens is easily proved by our development of a carefully planned, practical program to provide medical and health care for the aged. Last December, our House of Delegates unanimously adopted a resolution applying specifically to those of our population over 65 with reduced family incomes or modest resources. In treating these patients, physicians have been asked to accept a level of compensation that will permit the development of insurance and prepayment plans at reduced premium rates.

State and local medical societies have responded to this call by acting to implement the program on their own levels. Throughout the nation, societies are working out details and consulting with the health insurance industry to develop low-cost coverage for our senior citizens.

A number of policies already have been introduced by commercial firms. These include guaran-

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A former president of the southeastern section of the American Urological Association, Dr. Orr is a practicing urologist in Orlando. Graduating from Emory University School of Medicine in 1924, Dr. Orr served as a resident in urology and general surgery at the Lakeside Hospital in Cleveland prior to his moving to Orlando.

Dr. Orr has had a long and distinguished career with the American Medical Association, having served as Vice-Speaker of the House of Delegates, Chairman of the Federal Medical Services Committee, and Ex-officio member of the Council on Constitution and Bylaws, and also a member of the Council on Medical Service. He has made more than 50 contributions to the scientific literature.

teed-renewable contracts, "paid-up-at-65" and "65-plus" policies.

Another indication of American medicine's interest in the aged is the AMA's call for more facilities designed specifically to meet the health requirements of the elderly. These range from progressive care in hospitals to nursing homes to home-maker services.

5. The claim that only a government-run program could efficiently meet the health needs of the aged is one we have been hearing rather frequently in recent years.

I believe that regardless of what we do for the aged, we must preserve the spirit of individual freedom, flexibility, and *voluntaryism*. Certainly, I can think of no speedier way to wipe out all three of these necessary qualities than to have the government step in and dictate how the aged must be cared for. Although it may appear alluring on paper, no program to help the aged can hope to succeed without flexibility. I am sure no one would argue that all the diseases, ailments, and complaints of Americans could be treated by one drug. How then could the many varying needs of the aged be solved by one rigid formula?

Along with eliminating flexibility and voluntaryism, a government program also would be disastrously expensive. For example, there is now legislation pending before Congress to provide certain hospital, surgical, and nursing home benefits to most social security beneficiaries. This bill has been introduced by Representative Forand of Rhode Island.

Experts have estimated the costs of operating such a program could exceed two billion dollars. This would necessitate raising the social security taxes to a point where that segment of the population under 65 would be forced to finance an indeterminate amount of health care for those over 65.

Of course, any government plan would be compulsory, financially back-breaking, subject to political whim and political pressure, and hopelessly entangled in red tape.

6. The belief that there is nothing new about old age is a misleading one. From the days of Methuselah there have been instances of individuals living to exceptional ages. I think the word "exceptional" provides the key to the misunderstanding. Among past generations, those who lived into their 60's and above were the exceptions. That individuals now reach advanced age is nothing new. That millions of Americans are living to 70, 80, or 90 is new. This is the true revolution in aging.

Such then are six basic misconceptions about aging. I am sure you could name others, but I be-

lieve these are the most widespread and certainly the most harmful. Thankfully, though, we can refute each of these errors in the form of positive statements.

Tools to Battle Barriers of the Aged

1. A person at 65 has before him years of creativity and usefulness, provided he is offered the opportunity to remain an active member of society.

2. The vast majority of our 15 million old people enjoy reasonably good health, and they are not all in dire need of medical care.

3. The needs of our senior citizens are far more numerous than just health needs. They include social, economic, occupational, and psychological.

4. The physicians of America have taken an active interest in the needs of the aged. Our concern is such that a dynamic program has been set into motion to help provide low-cost health insurance for those who have been financially short-changed by our society.

5. Our program is designed to meet the health needs of the aged while preserving the dignity and freedom of the individual. It has a flexibility that no government-run program could provide, and our plan will not throw the elderly into a state of financial dependence on their fellow citizens or on the government.

6. The fact that more people are living longer is one of the greatest sociological and medical revolutions. We are still in the midst of this change, but we do not intend to stand still while history swirls past us. Our effectiveness in meeting the challenges of this new world of aging will depend ultimately on our understanding of its magnitude.

These are the six positive tools we can use to batter down the barriers surrounding the aged. But before we can use them, we must first act effectively and imaginatively to fortify the A.M.A. program and develop low-cost health care for the aged.

You, the members of the Medical Association of Georgia, working through your Committee on Aging, can give our plan your energetic support. I recommend strongly that you enlist the cooperation of civic and community groups to meet the needs of the aged in Georgia. A vigorous, dynamic effort on your part will assure the success of our program.

This is a case where each of us, you and me, can materially help our senior citizens. It is a challenge American medicine has already stepped forward to meet. I hope that every Georgia physician joins in this campaign to solve the health care needs of the aged.

1300 Kuhl Avenue

HYPERSENSITIVITY REACTIONS TO PENICILLIN

Edwin C. Evans, M.D., *Atlanta*

ONE OF THE GREATEST penalties that we must pay for the rapid progress in therapy which has taken place during the past 20 years is the occurrence of undesirable side reactions accompanying the use of some of the newer therapeutic agents. Since antibiotics have affected a greater segment of the population than any other field of therapy, it is not surprising that the first and most commonly used antibiotic, penicillin, has been responsible for more side reactions than any other drug. Although penicillin is virtually non-toxic and can be taken by many people in enormous quantities with no undesirable results, it will occasionally cause hypersensitivity in certain unfortunate individuals. Approximately 10 per cent of our population are potential candidates for sensitivity reactions to some allergen during their lifetime, and it is the members of this group who are most likely to develop hypersensitivity reactions to penicillin.

Incidence

In a nation-wide study of antibiotic reactions by the Food and Drug Administration covering 1954, 1955, and 1956,¹ 29 per cent of the nation's 685,655 general hospital beds were surveyed. There were 2,995 severe reactions to antibiotics. Two thousand five hundred seventeen (80 per cent) of these were caused by penicillin. Of these 2,995 severe reactions, 1,925 were not classified as life-threatening and 1,070 were life-threatening. Eighty-four per cent of each group was due to penicillin. Of the 901 persons reacting to penicillin 83 died (mortality rate nine per cent). Seven hundred ninety-three of the reactions were of the anaphylactoid type with 63 deaths (nine per cent). One hundred seventy-nine anaphylactoid reactions occurred in 1954, 231 in 1955, and 301 in 1956. I do not know of any statistics covering the years 1957 and 1958 but an increase would be expected in each of these years, especially in those reactions of the anaphylactoid type. However, most penicillin therapy is given in the office or in the home and thus it seems quite

Amounts of penicillin greater than those capable of producing antigenic effects have been found in syringes boiled for prolonged periods of time.

likely that this study shows only a portion of the true picture because these were hospitalized patients. It is probable that numerous minor reactions and many fatal anaphylactic reactions never reached a hospital. For instance, Rosenthal² reported from the New York City Coroner's Office 30 fatal reactions, 23 of whom did not reach a hospital. Of the seven who died in a hospital, four were given the penicillin at the hospital where death occurred. Three of these 30 patients had antihistamine injected with the penicillin because it was felt that this procedure would make the administration of penicillin less risky.

Types of Reactions

The various types of allergic reactions to penicillin have been well summarized by Zimmerman³ as follows:

Type I: Delayed Reactions:

- (a) Most common allergic reaction.
- (b) Response of initial sensitization.
- (c) Incubation period usually 7 to 14 days.
- (d) Resembles serum sickness with fever, urticaria, and joint pains.
- (e) Skin testing and history of previous reaction are negative.

Type II: Accelerated and Immediate Reactions.

- (a) Fortunately uncommon.
- (b) Occurs if there has been a previous exposure to penicillin but there might not have been a previous overt sensitivity reaction.
- (c) Incubation period brief—five seconds to an hour; one or two days in the accelerated type which blends with Type I reactions.
- (d) Manifestations may be mild but are often extremely severe.
- (e) Serum sickness, angioedema, and anaphylaxis may occur.
- (f) Estimated that over 1,000 deaths have occurred in the United States from this type of reaction.

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- (g) Some will have positive skin tests and/or histories of previous penicillin allergy. Many will not.

Type III: Hyperergic Reactions.

- (a) Rare reactions with more intense cutaneous, vascular and visceral phenomena.
 - (1) Bullous, purpuric, and exfoliative eruptions.
 - (2) Loeffler's syndrome.
 - (3) Hypersensitivity angitis.
- (b) May follow Type I or Accelerated Type II reactions.
- (c) Preliminary history and skin testing usually negative.

Type IV: Erythematous-vesicular or "Id"-Like Eruptions.

- (a) Common, second only to Type I in incidence.
- (b) More common in men.
- (c) Occur hours or one or two days, usually, after penicillin exposure.
- (d) Affect hands, feet, and groin with vesicles and bullae which might become generalized.
- (e) Possibly an activation of silent sensitization induced by previous fungus diseases of the skin.
- (f) Preliminary skin testing may be positive or negative.

Type V: Contact, Eczematous dermatitis.

- (a) Due to topical therapy or occupational exposure.
- (b) Vesicular dermatitis at site of contact.
- (c) Patch test positive.
- (d) Absorption through skin may lead to any of above reactions Type I to IV.

Factors Favoring the Development of Penicillin Sensitization

It is clearly evident that the majority of persons hypersensitive to penicillin are those who have been exposed to it previously. Patients with a present or past allergic diathesis react more easily and more severely. Any type of penicillin preparation or any route of administration may be responsible for the production of sensitization. However, certain preparations such as penethamate hydriodide ("Neopenil") are associated with a greater incidence of sensitization while others such as penicillin O seem to produce a lesser incidence. Local applications produce sensitization frequently. Intramuscular injection appears to produce hypersensitivity more readily than oral administration. It has been shown that some pathogenic fungi on the skin produce substances similar to penicillin⁴ and it has been suggested that this might account for some instances of sensitization when there is no history of previous penicillin administration. However, the available data concerning this mechanism are still inconclusive.⁵ Numbers of cases of hypersensitivity to penicillin have occurred in individuals with an occupa-

tional exposure (nurses, doctors, pharmacists, farmers, etc.). Although I am not familiar with any report of proved sensitization from penicillin-contaminated syringes it is highly probable that sensitization by this method does occur. Coleman and Siegel⁶ have shown that although boiling of penicillin induces a rapid fall in antibiotic potency, traces of penicillin could still be found after 16 hours of boiling. Amounts greater than those capable of producing antigenic effects have been found in syringes boiled for prolonged periods of time.⁵

Penicillin Contamination of Food and Drugs

Ingestion of penicillin in the molds of roquefort and bleu cheeses has caused reactions in highly sensitive persons.³

After spot-checking 1,700 grocery store samples of milk from the 48 states and the District of Columbia, the Food and Drug Administration reported in 1957 that 11 per cent of the samples were contaminated with penicillin, the maximum concentration being 550 units per quart of milk.⁷ Several other reports of significant amounts of penicillin in milk have been published since 1948, when the dairy industry first published a complaint that some milk was so heavily contaminated with penicillin that it could not be turned into cheese. It has been estimated that 25 per cent of the dairy cattle in the United States have mastitis at any given time.⁸ This disease, which affects one or more of the quadrants of the cow's udder, may be caused by many strains of bacteria including staphylococcus aureus and streptococcus agalactiae. Milk from cows with mastitis has an unpleasant odor and taste. Mastitis also cuts milk production and reduces the butterfat content of the milk. Elimination of mastitis as rapidly as possible is, therefore, of much importance to the dairyman. Until 1957, one million units of penicillin was instilled into the udder at any suspicion of mastitis. At least 49 per cent of this penicillin could be recovered from the milk. Since 1957 the treatment package contains only 100,000 units. After discussing this problem with 30 authorities in the fields of antibiotic therapy, allergy, and pediatrics in 1956, a Medical Advisory Panel to the Commissioner of the Food and Drug Administration stated that, in the opinion of many of these authorities, the quantities of penicillin found in market milk are not likely to modify the oral or intestinal flora, cause the emergence of resistant strains, or provoke sensitization of the consumer but might well cause a reaction in a highly sensitive individual.⁹ This panel recognized that the grading of milk could be improved if the producer lowered the bacterial count by the addition of penicillin but they felt that most of the penicillin was reaching the

milk supply through the improper use of mastitis preparations. An educational program of considerable magnitude was suggested urging dairy farmers to discard all milk following penicillin treatment of mastitis for at least three days after treatment. Such a warning has been included in the mastitis treatment package for several years. The Agriculture Department has attempted without success to develop for incorporation in the mastitis preparations a dye which would produce a color for several milkings after instillation. In January of this year Zimmerman⁷ reported four cases of allergic reactions produced by penicillin-containing milk.

Poliomyelitis vaccines contain from less than one unit to a maximum of 200 units of penicillin per cc. There have been no reports of sensitization of an insensitive person to penicillin by giving polio vaccine but there have been a few proved instances of allergic reactions to the penicillin of polio vaccines in highly sensitive individuals.¹⁰ Wyeths polio vaccine contains less than 0.001 units of penicillin per cubic centimeter and probably less than 0.000001 unit per cubic centimeter of vaccine.

Duration of Penicillin Sensitivity

The duration of penicillin sensitivity is difficult to predict. Generally, the more severe the reaction the longer the hypersensitivity will last but this is not always true. Under no conditions should it be assumed that hypersensitivity to penicillin no longer exists because the previous reaction was a minor one.

Clinical Recognition of Penicillin Sensitivity

Each time the physician is faced with a patient requiring penicillin he should carefully search for a personal history or family history of allergy and the patient should be questioned in detail concerning topical applications, inhalations, oral and parenteral administration of penicillin. A careful inquiry should be made for specific symptoms such as skin rashes, itching, swelling, tingling, cardiorespiratory sensations, etc. which might have occurred following any previous administration of penicillin. Sensations which occurred immediately after the drug was given should be regarded as more serious than those which occurred several days later.

All subjects with a personal or family history of allergy or a history suggesting previous sensitivity reactions to penicillin should be considered as potential victims of a serious hypersensitivity reaction if the drug is again administered. There is no good agreement as to what course of action to take in these patients except that the use of another

drug is strongly recommended if this is at all feasible. However, most authorities agree that if penicillin must be given to such a patient, some effort should be made to establish the presence or absence of hypersensitivity immediately preceding the readministration of the drug. Practically all the methods which have been suggested are too involved and time-consuming for the average physician in private practice. However, the following simple method has been suggested:^{11,12} after loading the syringe with the preparation to be used a drop of this material is placed on the volar surface of the forearm. A scratch 3 or 4 mm. long penetrating the outer layer of skin is made through this drop. Wait ten minutes. If a wheal develops immediately (in less than a minute) rub 1:1000 adrenaline into the scratch. If symptoms such as dyspnea, urticaria, itching, etc. develop give 0.5 cc. of adrenaline subcutaneously and apply a tourniquet above the scratch. Confusion arising from dermatographia may be avoided by a second scratch used as a control. If further tests of sensitivity are desired when the scratch test is negative a conjunctival test may be used¹² or an intracutaneous test using more dilute preparations of aqueous penicillin (such as 0.01 cc. of a solution containing 1,000 units per cc.)¹³ might be performed. Both of these methods are more hazardous than the scratch test. The intradermal test is the most sensitive method. Occasionally conjunctival testing will detect hypersensitivity when the scratch test is negative.¹² The present situation regarding skin testing has been summarized as follows:⁵ "A positive immediate penicillin skin test signals likely anaphylactic allergy to penicillin. The use of penicillin is then contraindicated. False tests rarely occur. On the other hand, a negative skin test does not exclude penicillin allergy and a severe reaction to subsequent penicillin administration may occur. Despite this limitation, the use of skin testing is at present the only available objective practical diagnostic procedure for revealing penicillin sensitivity. Properly performed and evaluated, it may be a useful aid to the physician in individual cases . . . Because of the sometimes equivocal results of penicillin skin tests, they cannot be relied on alone but should be considered one of the precautions which can be taken for reducing the incidence of penicillin reactions." It must be emphasized that the skin tests and the conjunctival test are of value only in predicting the serious, immediate or anaphylactic reaction. There is no test to predict the delayed reactions.

Prevention of Sensitization to Penicillin

Penicillin should be used only when careful clinical judgment indicates that there is a definite reason

for its use. Patients with an allergic diathesis should be educated to request avoidance of penicillin except on good indication. Since depot penicillin seems to produce more sensitization, perhaps aqueous penicillin would be preferable in those of allergic constitution. Combinations of penicillin with other drugs should be used only when the combination is definitely indicated for the same reason. Ineffective lozenges and local applications of penicillin should be completely abandoned. Since there is some evidence to suggest that the oral route of administration produces less sensitization than the parenteral, penicillin should probably be given orally when feasible. Continued efforts should be made to educate the public as to the dangers of the promiscuous use of penicillin. It has been estimated that 10 per cent of the fatal cases have resulted from self-medication.

Prevention of Penicillin Reactions

Obviously the best method of prophylaxis of hypersensitivity reactions to penicillin is to diminish the chances of inducing sensitivity in the population at large by methods such as those just mentioned in the preceding paragraph. Adequate time must be taken to elicit a history of allergy and a detailed history of any previous penicillin administration should be obtained. If it is very important that a patient with an allergic diathesis or a previous history of an allergic penicillin reaction be given the drug again, skin testing should be performed before penicillin is again administered. In all cases of potential or proven hypersensitivity to penicillin another suitable antibiotic or chemotherapeutic agent should be given if one is available.

In an attempt to avoid anaphylactic reactions to penicillin, antihistamines have been given parenterally mixed with the penicillin or separately by the oral or parenteral routes. It has been indicated previously that this procedure is not reliable in preventing anaphylaxis. ACTH and adrenal steroids also cannot be depended upon to prevent the anaphylactic reactions.

Technique of Injection

The injection should be made slowly and should be given deeply into the muscle with great care to avoid intravenous administration. Many authorities have suggested giving the injection into one of the upper arms so that a tourniquet may be applied proximal to the injection in case of reaction. If possible the patient should be kept under observation for 15 minutes after the injection. Adrenaline and possibly also penicillinase should be immediately available at any time that an injection of penicillin is given

so that they may be administered within one minute in the case of an anaphylactic reaction.

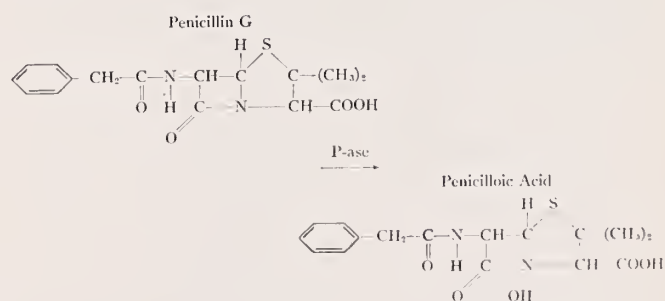
Treatment of Allergic Reactions

For the anaphylactic reaction the first weapon should always be adrenaline. It may be given intravenously, intramuscularly, subcutaneously or by local infiltration or by any combination of these routes as is indicated. The usual dose is 0.5 to 1.0 cc. of a 1:1000 aqueous solution. A tourniquet should be applied proximal to the site of the penicillin injection if possible. Oxygen may be necessary as well as vasopressor agents. If the patient survives for several minutes antihistamines, ACTH, and adrenal steroid therapy may be added. Penicillinase 800,000 units should probably be given intravenously as suggested by Becker,¹⁴ although there is some doubt that its action is rapid enough to be life-saving in many instances of the anaphylactic reactions.

In the "late immediate" or delayed reactions one should, of course, discontinue the penicillin. Penicillinase 800,000 units should be given intramuscularly and repeated in 96 hours if necessary. Antihistamines, ACTH or adrenal steroids also are usually indicated.

Penicillinase

Penicillinase (Neutrapen®) is sold commercially by the Schenley Laboratories. It is an enzyme which is formed by several bacteria, including the staphylococcus and *B. coli*, and is produced commercially from *Bacillus cereus*. Penicillinase is specific for its substrate penicillin which is hydrolyzed into penicilloic acid.



Penicilloic acid is devoid of any antibacterial activity. In some 25,000 to 50,000 inoculations of penicillinase there were no serious reactions. However, there was one report recently of an anaphylactic reaction attributed to penicillinase.¹⁵ Becker¹⁶ demonstrated that this substance hydrolyzes penicillin so rapidly that one hour after injection of 100,000 to 800,000 units of penicillinase no circulating penicillin could be found in persons who had received two million units of penicillin over a period of a day or two. Often the effects of the penicillinase seem to

last as much as seven days. Penicillinase has been used intramuscularly with satisfactory results in many instances of penicillin reactions. It is particularly useful in delayed reactions of short duration. Its substrate penicillin which is hydrolyzed into travenous use should probably be tried in cases of anaphylactic reaction to penicillin after adrenaline has been given.

Conclusion

Penicillin has saved tens of thousands of lives in this country and throughout the world and has reduced morbidity and complications in millions. With the increasing use of penicillin more and more people will be exposed to its sensitizing effects and hypersensitivity reactions are likely to occur in increasing numbers. The incidence of delayed reactions where the appearance of sensitivity and the occurrence of the reaction follow the first administration of penicillin will probably remain fairly constant. On the other hand, as more and more people receive penicillin in repeated doses it is reasonable to expect that the incidence of immediate anaphylactic reactions will increase since this reaction is dependent upon previous sensitization. This type of reaction is uncommon at present but it is of great importance because of the fatalities which occur.

In attempting to prevent the serious hypersensitivity reactions to penicillin it is important to educate the public concerning the dangers of the indiscriminate use of the drug.

Since no method of penicillin administration can safely insure that sensitization will be avoided, the physician should have clear-cut indications before prescribing penicillin. If there are contraindications to

its use, the hazards involved should be balanced against the extent and nature of the disease being treated. Caution is necessary but excessive caution should not lead to withholding penicillin when there is a definite indication for its use.

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AGE GETS BREAK IN COURT

AN INDIANA APPELLATE COURT has ruled that a man cannot be forced to retire just because he has reached 70 years of age.

The finding reversed an earlier circuit court decision that upheld the Board of Public Works and Safety, Ligonier, Ind., after it had dismissed Elmer Boles, 71, as police chief.

In a defense of elderly persons, the Appellate Court judges reminded advocates of compulsory retirement programs that "many lawyers and jurists die with their boots on in the 80s."

The judges also noted that a man over 90 now is serving in the U. S. Senate. Sen. Theodore Green (D., R. I.) was 92 on Oct. 2.

Common law has never held, the court said, that a person attaining 70 "suddenly lost status in being a man and, as a matter of law, became a disabled shell of his former self so that he was deemed incapable of performing the functions he had been performing 69 years and 364 days prior thereto."

—AMA News

THE STATUS OF ALCOHOLISM—

WHERE DO WE GO FROM HERE?

Alcoholism is but one manifestation of a tremendous mental health problem.

FROM THE TITLE OF this paper, there is an implication that we know exactly where we are, and are now looking for further direction into the future. This may or may not be true, but before we start to look toward where we are going, perhaps it might be wise to pause for a moment and look at where we are.

A great deal has been written and stated about alcoholism. One can hardly peruse a periodical today without seeing somewhere in it a reference to this disease. It has become a popular subject of discussion. There are many statements about it from various sources, both lay and professional. Let us consider some common statements made by authoritative sources which have become by-words in our literature.

Alcoholism Is a Disease

Late in 1956, the American Medical Association, at its meeting in Seattle, placed before its House of Delegates a resolution stating that alcoholism is a disease properly within the purview of medical practice. It was adopted unanimously by the House of Delegates. This was official acceptance by the greatest medical organization in the world that alcoholism is a disease. Subsequent to that action, the same type of resolution was passed by the American Hospital Association. Here, then, was another health organization which had accepted this statement. The same premise long ago was accepted by Alcoholics Anonymous, a fellowship of over 200,000 people who are suffering from this illness. While psychiatry for the most part looks upon alcoholism more as a symptom of an underlying disease

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than as a disease itself, it does recognize that in such cases the symptom becomes of sufficient importance to be considered an entity which must be treated. Psychiatrists agree that one must recognize and treat alcoholism, at least until the underlying basic mental problem which may be present can be reached.

In all these references, however, we are dealing with understanding by enlightened professional people, or the patients themselves who suffer from this disease. Naturally, these particular people wish to study and learn about alcoholism. They have a special interest in this field, and because they are trained professionally to do so, or because they have a special interest, their minds are open. However, even all of these people do not feel exactly the same way about alcoholism. Not all of those suffering from alcoholism look upon it as a disease. Only those who want help and feel that they should have help recognize that their problem could be an illness. Many professional people with varied backgrounds still refuse to accept alcoholism as a disease, and unfortunately too many of the people suffering from the illness, as well as a great part of the public, have not accepted it.

When I say that the majority of the patients and the public at large has not accepted alcoholism as a disease, I do not mean they have actually made such statements. Conversely, various polls have in-

Presented at the annual meeting of the Metropolitan Atlanta Committee on Alcoholism, May 9, 1959, Atlanta, Georgia.

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licated that the people questioned about alcoholism say they do believe it is a disease. In my opinion, however, this is an intellectual acceptance of the problem, and only on an intellectual basis do they accept it. Emotionally, many of these same people reject alcoholics, and if one rejects an alcoholic emotionally, he rejects alcoholism as a disease, despite his statements of acceptance. Witness the poll taken in one western hospital where alcoholics are accepted as patients without hesitation. The majority of the nursing personnel, in a questionnaire specifically designed for them, stated they believed that alcoholism was an illness, that alcoholic patients were entitled to hospital care, that they are not always troublesome, that they respond well to treatment, and that they are worthy and capable people. Most of the nurses felt that they properly belong in general hospitals, and should receive the same treatment as any other sick patient in the hospital. On further questioning, however, with specific queries designed to uncover the emotional reaction to such patients, a surprising number of the same nurses indicated that they did not care to nurse such patients, would rather that they were not on the hospital floors, and that they, the nurses, felt there was indeed a moral problem with these patients. This interesting survey of this particular hospital appears in a published monograph. It is quite illustrative of the statement which I made previously, that intellectual acceptance does not necessarily mean actual acceptance.

In the medical profession, this same type of re-

action is true to a considerable extent. An increasing number of physicians is willing to grant that these people are sick and deserve and should have treatment, both in the hospital and in their private offices. Further discussion with the same physicians, however, discloses that they do not have sufficient time to spend with such patients, that they would rather refer them to other agencies or disciplines, and that once the acute stage of intoxication is past, there is little that they, the physicians, can do toward helping these patients. General practitioners, who otherwise demonstrate considerable compassion toward all sick people, lose patience with alcoholics because they are so frustrating and time-consuming. Even among psychiatrists, one often hears that alcoholics are refused consultation because of their untoward behavior. Still, most of these physicians are willing to concede that alcoholics are sick people.

How about the patients themselves? It surprises me to find how often among these patients there occurs the intense feeling that they have been derelict, weak, and guilty. They speak of alcoholism as a disease, but their attitude is both wistful and wishful, each hoping against hope that he is only a sick person and not an evil one. Many of them believe that they are sick, but here again, it is only on an intellectual basis. Emotionally, they feel guilty, and when questioned closely, many will admit that within their own hearts they feel that this is a moral weakness. The mere mention of the possibility of a mental problem panics them, and their fear is that it is a result of their drinking rather than a basis for it. The spouses of alcoholics are prone to vacillate in their attitudes, depending upon their particular

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emotions at the time of discussion. While still economically dependent upon an alcoholic spouse, a man or wife may often retain sufficient affection for the patient to consider his or her spouse a sick person. As the illness progresses, and the patient becomes more intensely ill, his actions may become more difficult; then the spouse is less willing to accept him as a person with an illness. Finally, when patience is at an end, the trouble ceases to be a disease, and becomes a dereliction from which the spouse wishes freedom.

And so while the statement "alcoholism is a disease" has gained in popularity, and is accepted intellectually by most people, actual acceptance of the affected person himself is a long way off. Lip service is not enough. Acceptance of alcoholism as a disease will come only when the stigma has been removed and there is greater understanding of the basic problems.

Alcoholism Is a Public Health Problem

Here, again, we find a popular statement. The premise has been accepted by government agencies, public health agencies, lay health agencies, social workers, sociologists, and many other professional people. Those particularly interested in this field, of course, have made this statement over and over. How much convinced are they? Intellectually, they speak about it, write about it, and discuss it at various levels of government and education. How many of these agencies, however, are willing to champion the cause of the alcoholic patient when it comes to appropriation of funds for education, diagnosis, treatment, and research? Sometimes a token appropriation is made to satisfy those proponents who have worked in the field. Often, it is made through pressure brought about by one individual who is particularly interested in the subject because of a personal experience. However, the money spent in research on alcoholism is woefully inadequate. Compared to the funds available for the study of other diseases, the amount devoted to the problem of alcoholism is infinitesimal. This is true in spite of the fact that millions of people in this country are afflicted with this illness, and that they number many times that of the other diseases being studied. As a matter of fact, in many areas of the country there is tremendous resistance against expenditures for research on alcoholism by those who feel that there are other areas of health which are of greater importance. It would be presumptuous of me to state that research on alcoholism should take precedence over other diseases, but it is reasonable to expect that a disease which involves such a tremendous number of people annually and eventu-

ally kills so many, and which, in my opinion, is preventable, should have as little research as it does.

Alcoholism Is a Social Phenomenon

In this, we have another popular statement made by sociologists, historians, and ecologists. In reviewing the incidence and progress of this disease, I think that a great deal can be said in support of this statement. If this be true, then the same forces which brought about this sociological phenomenon could be modified if the proper methodology were employed. If such modification is impossible, or impractical, then new forces could be applied with the objective of producing other sociological phenomena to counteract the first. As of today, however, we find alcoholism a frighteningly prevalent disease in a culture which encourages drinking of alcoholic beverages and which has an appalling tolerance for drunken behavior. "There, but for the grace of God, go I," seems to be the attitude of most people when drunken behavior is witnessed. There is a hesitancy and a fear of censuring such behavior. One does not wish to be classified as a "square." One does not wish to be called a "blue-nose." "He is not hurting anyone." "He is harmless." Such statements are common. They may be true for the most part, but for that one out of 15 persons who might be an early alcoholic, they are the grossest of misstatements. If we could only be sure which one of the group was susceptible, we could be very generous about the other 14. To the one susceptible, however, and early in the disease it could be any one of the group, the intoxicating behavior may portend tragedy for himself and his family.

A cocktail party is an accepted social function, and a very pleasant one. A preprandial drink can be a very pleasant preface to dinner. However, there seems to be a prevalent idea that just to drink is not enough. One must feel the drink. One must attain the feeling of euphoria, or why start at all? Do not misunderstand me. I am not against drinking. I do not favor prohibition. I am not anti-alcohol. However, I do think that some changes could be made in our cultural standards. We should not encourage drinking thoughtlessly as though it is completely harmless. We must always keep in mind that one out of every 15 adults is suffering from alcoholism in one of its stages. The statement that "One won't hurt you," can be a reassurance that applies to 14 others, but a false assurance to the fifteenth that could spell disaster.

Alcoholism Is a Human Tragedy

Alcoholism is extremely insidious in its onset. In its early stages, it cannot be differentiated from

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social drinking. Its victims are the last to recognize it. It engenders defensive attitudes in those afflicted, and even those close to him. It becomes overtly manifest usually only after a long period of involvement. It brings misery to its victim, his family, and his friends. It means economic disaster for those involved. For all of us, it is an expensive problem because it affects us all economically. Unfortunately, there has been no appreciable diminution in the prevalence or the effect of this disease in the last ten years, despite intense educational efforts by those interested. It is true that during this period many alcoholics have achieved recovery. Many have been rehabilitated to new and healthy lives. Unfortunately, however, new ones have taken their place. In spite of the tremendous strides which have been made in the direction of recovery and rehabilitation, no great inroads on the entire problem have been made. But it is not as discouraging as this statement might imply. There is a groundswell to be felt, which presages better things to come. As of now, however, I think that the situation which I have described is a fairly accurate one, a reasonable view of the problem from where we now stand.

Where Do We Go from Here?

If alcoholism is a disease, and is accepted as such, then let us treat it as such. Let all physicians, all hospitals, and all nursing personnel realize that alcoholic patients are entitled to adequate treatment without unnecessary moral overtones. Let research in the field be carried on to the same extent as with other diseases. Physicians, clinics, hospitals, and required medications should be available to any of these patients.

In appropriating funds for research and treatment of alcoholism, many states have resorted to taxing alcohol. Such taxes have been earmarked for the problem of alcoholism. Is this not just one more evidence that alcoholism is not accepted as are other diseases? I can see no objection to a tax on alcohol. It can be made as high as the legislators wish. However, I cannot understand earmarking such funds for alcoholism. Why not put these same funds into the general treasury? If alcoholism is a disease, let the funds for its study be taken from the general treasury, just as funds for other diseases are provided from the same source. Certainly, it is agreed now that alcohol is not the cause of alcoholism. Why differentiate between it and other diseases in earmarking funds for its study?

Alcoholism Is a Public Health Problem

If alcoholism is a public health problem, and is accepted, let the public health authorities study its

epidemiology, emphasize its early detection, and recognize the communicability of this disease, as has been done with other public health problems. Let these authorities provide the facilities and the money for proper research about alcoholism, and let the amount of money be comparable with its prevalence. As can be expected, this can require a tremendous amount of money. With such appropriations already made, and more available, sufficient research could be made into the physiological, biochemical, microbiological, and metabolic fields to determine those physical factors which differentiate the alcoholic from the normal person. Such studies must be done by a highly specialized team of scientists, working directly with alcoholic patients in an environment which would be conducive to extensive investigation in this specialized field. Answers to such problems do not come quickly or easily. It is necessary, therefore, that sufficient sustained interest and effort be brought to bear to produce results. In many areas, public health personnel are doing all this. It should be in every public health program. Sufficient interest must be stimulated among constituents to influence their representatives in various legislatures to press for research in this tremendous public health problem.

Sufficient study on the epidemiology of alcoholism has not been made in the public health field. I imagine that has been largely due to the lack of funds. The communicability of most diseases with bacterial etiologies is well known. Too little emphasis has been placed upon the communicability of mental or emotional problems, particularly on that of alcoholism. There has been sufficient evidence through history and experience that alcoholism is more likely to occur in families where there has been an alcoholic parent. It occurs more in this type of family than in those free of the disease. It is also conceded that the disease is not hereditary. The communicability of this illness, therefore, becomes one of the important and outstanding problems in prevention as a public health measure. Work along these lines should constitute one of the big efforts of the future. As with any other disease, early detection and treatment gives the patient a much better chance of recovery, than the application of treatment later in the disease. As with many other illnesses, the solution to the problem may not necessarily be the successful treatment of the involved patients, but rather the prevention of future patients. Prevention of any disease is a public health function. This is one with which public health departments must contend.

Ideas Are Communicable

As a social phenomenon, alcoholism is recognized

by many scientists and educators. The cultural forces which have brought about this social phenomenon are varied and many. If such forces have produced such a phenomenon, is it not possible, then, for us to generate new forces, new ideas, new approaches, and new facilities for reversing this result? Ideas, like diseases, are communicable. Whole nations, in a comparatively short time, have been known to change their ways of living. Indoctrination of thoughts, sometimes referred to as brainwashing, sometimes referred to as mass media propaganda, and more often referred to as education, has been known to revise human ideas and methods of thinking. What is right and what is wrong is not always easy to determine. Moral values change. Most of us recognize, I believe, that often these are matters of time and place. What was acceptable generations ago may not be acceptable today. What is wrong in some parts of the world is considered right in others. Morality, therefore, becomes a question of education, training, understanding, and background. Again let me remind you that where no harm results, drinking need not be objectionable.

Intoxication—Acceptable or Not?

It has long been recognized that in certain cultures, drunkenness was not tolerated. The slightest indication of excessive drinking or intoxication was frowned upon, and the individual affected was often socially ostracized. Children learned this early in life. To such individuals, intoxication was reprehensible. In such cultures, the occurrence of alcoholism was a rarity. It is true that humans will often seek escape from reality by various devices, but where one's background and training has been to avoid alcohol for such an escape, individuals do not resort to drinking.

On the contrary, in other cultures, excessive drinking is often acceptable. Intoxication is tolerated, and in some areas, even encouraged. In such areas, chronic alcoholism is quite common. Omitting for the time being that small percentage of people who are sensitized to alcohol from the first drink, it is conceded that the vast majority of alcoholics become physiologically addicted only after many years of drinking. Training, I submit, is one way of discouraging alcoholism.

The desire on the part of most people to conform sometimes proves an obstruction to their recovery. It is extremely important that all of us realize that many such people are in our midst. It is unfair for us to make their recovery more difficult. Hosts and hostesses must be encouraged to remember that some of their guests may find embarrassment in refusing to drink in a society where it is so prevalent. The thoughtful host and hostess

will have available soft drinks, fruit juices, and other non-alcoholic beverages which their guests may choose without embarrassment. Under no circumstances should anyone be coaxed to drink alcohol, and a "No, thank you" should be taken exactly as it is meant. "One won't hurt you" is a dangerous statement, and born only of ignorance. The possibilities of error are too great.

Prohibition Changed Many Ideas

Only a few short years ago, when prohibition was the law of the land, drinking by young people became the smart thing to do. I dare say that before prohibition, there had been drinking, even excessive drinking, but one rarely saw young people of high school age indulging, and certainly not girls. Alcoholism, I am sure, also existed. There is no doubt that there was excessive drinking in many social circles. Inebriates, however, were frowned upon, and the alcoholic woman was considered fallen. Mostly, such excesses were found among the ignorant and the uninformed, although I am sure it existed among all classes. During prohibition, however, when it became smart to drink, more and more young people indulged. It was the thing to do, and there was considerable encouragement by everyone to flout an unpopular law. The flask on the hip became popular. It became the badge of the sophisticate. Home brew and the speakeasies were popular evidence of outsmarting the law.

Since these untoward results were brought about by a new way of thinking, would it not be possible to reverse the process? Would it not be possible to make it smart not to become intoxicated? Should the slogan not be "If you drink, never drink excessively," and could this not be made the mark of the real sophisticate, the mature person, and the well-adjusted individual? We cannot consider prohibition. This has never succeeded. However, to recognize the excessive drinker or the chronically intoxicated drinker as a poorly adjusted person who needs help rather than a smart and sophisticated one might more properly classify him, and make him and those close to him conscious of the fact that he needs help. It is imperative that we teach everyone that alcohol is a powerful drug, and that when one is in need of such a drug, or becomes dependent upon it, that person is sick, is far from normal or well-adjusted, and that he needs help. Would this not be one way of making everyone more conscious of the existence of alcoholism? This is another goal toward which we must reach.

Improve Mental Health—Combat Alcoholism

Actually, we must concede that alcoholism is

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but one manifestation of a tremendous mental health problem. In order to combat alcoholism, one must work toward combating the even larger area of general mental health, because it is from this area of the emotionally disturbed that the alcoholic is recruited. If we can improve the general mental health of all, then the chances of any of them becoming alcoholics is reduced. The ability to rear future generations to living in the world, adequately adjusting themselves to its many problems, must be our eventual goal. We live in a highly complicated, intensely competitive, and sadly un-united world. It is unrealistic to lead young people to believe the world to be as we would like it, rather than what it is. To prepare such young people properly, there must be sufficient groundwork laid for facing the realities which they must meet as their lives progress.

There are certain principles which they must learn. They must be taught at an early age that one does not succeed every time, that one must adjust and compromise, that each of us has limitations, and responsibilities. They must be taught that each has these responsibilities which he must carry to the best of his ability. He must learn that the results are not always the best, but that if they are not good enough, there may be limitations to account for them. If such limitations exist, they must be accepted. Children, as well as adults, must be taught that it is important to accept inevitables, and yet in the face of the inevitable, they must still keep trying. They must be taught not to be discouraged easily, not to expect that every problem can be satisfactorily solved. Such education is not easy. It must be carried on gradually from early youth through adulthood. It must be broad-based and extend over all disciplines and all ages.

Perhaps the best way in which this can be accomplished is by example. Who can better set such an example than those of us who recognize these precepts? Young people, as a rule, are extremely observant, and see much more and understand much more than we give them credit for. This must always be kept in mind. Children watch adults very carefully, and all too often, the patterns set by adults are followed by children. When these patterns are wholesome, the child benefits. This, then, places a tremendous responsibility upon the adult. This applies not only to parents, but to teachers as well, and here is another area which must be thoroughly explored.

The teaching in the public schools, as well as private schools, must include subjects such as alcoholism. In this teaching, it is very important that

the children be taught the truth. There have been so many distorted statements regarding alcohol and alcoholism that conflicts are continually created in the minds of children. To tell a child that alcohol is poisonous or brings about deterioration of brain tissue, or many other such exaggerations as have been taught, and have that same child go home and watch his parents partake of alcoholic beverages creates in the child's mind a distrust of his teachers. Such exaggerations and misleading statements must be avoided. Children must be taught the facts regarding alcohol and the effect of it. Lessons on this subject must be taught in full without exaggeration. Different cultures have different attitudes toward drinking. These various cultures and their backgrounds must be explained to children, and a tolerance and respect for other cultures must be learned.

The teacher's attitude in this matter is of extreme importance. The true facts about alcohol and its use in the various cultures must be imparted without personal emotional involvement of the teacher. This can be very difficult for the teacher at first. When there is a background of education and training in a culture other than that of the children who are being taught, the conflict may be the teachers'. However, this tests the ability of the teacher to impart knowledge without involving his own emotions. Teachers must be taught to handle such emotionally charged subjects with an objectivity which is of extreme importance for proper unbiased presentation. They can get this type of training only in schools of education, where programs dealing with the subject of alcoholism are taught adequately.

Teach Truth—Live Truth

It behooves all of us then to carry out these precepts which we try to teach others. We must impart to others with whom we come in contact the knowledge of the subject which we now have. We must teach it as fully and truthfully as we can in the light of the scientific facts as we know them. In spite of the vast uncharted areas which still challenge us on the subject of alcoholism, there are certain facts of which we are cognizant. Various recognized theories can be taught, and the reasons for such theories. This will stimulate thought in those who hear them. More than that, we must lead our own lives so as to set an example for those we teach. If, then, in the light of what we know and what we teach, we can help those whom we are teaching to proper adjustment of living and understanding of the forces which may lead to alcoholism, then perhaps with such enlightenment, we will be able to see where we go from here.

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J. M. A. GEORGIA

BENTYL WITH QUIACTIN IN GASTROENTEROLOGY

Charles W. Hock, M.D., *Augusta*

With this new combination 95 per cent of those patients tested obtained good or fair relief.

AMONG THE SHOCK ORGANS most commonly involved in neurogenic disorders are those of the digestive system. The gastroenterologist, therefore, has observed with as much interest as the psychiatrist the recent developments in psychopharmacology. His patients require attention to the psyche as well as to the soma and he is constantly looking for useful new phrenotropic agents.

For many years, the drugs most commonly employed in the treatment of anxiety and tension have been sedatives such as the barbiturates and the bromides. Unfortunately for many patients, the anti-anxiety effects of these drugs are synchronous with their depressant effects. For other patients, these sedatives may result in a variety of undesirable side reactions. The development of tranquilizing agents has been a major pharmacologic advance and it now appears possible with some of these new drugs to separate relief of anxiety from drowsiness. In the case of one new combination, Bentlyl with Quiactin,* this ability has been observed in patients with a variety of complaints of gastroenterologic origin.

Bentlyl® (beta-diethylaminoethyl 1-cyclohexylecyclohexanecarboxylate) hydrochloride has been demonstrated to possess both a parasympathetic (atropine-like) depressant and musculotropic (papaverine-like) action on smooth musculature of the gastrointestinal tract.¹ Bentlyl® is more effective than the belladonna group of antispasmodics and offers the advantage of virtual freedom from the usual pupillary, secretory, and cardiac effects of the belladonna alkaloids. Sustained relief of a variety of gastrointestinal symptoms by enteric-coated tablets has been reported. Because of its long duration of

action, this form of Bentlyl® has proved to be particularly useful in preventing early-morning distress.²

Quiactin® (2-thyl-3-propylglycidamide) is an internuncial neuron blocking agent that attenuates polysynaptic reflex arcs (flexor and inguomandibular reflexes) and has no effect on monosynaptic reflexes (patellar).³ It is structurally unrelated to sedatives or tranquilizers in current use and does not appear to have a soporific effect.⁴ Quiactin® has no effect on respiration except in toxic doses. It safely improves behavior in the irritable, quarrelsome patient and calms the restless, tense patient.

Bentlyl with Quiactin®, a combination of non-narcotic synthetic compounds, provides the safe antispasmodic properties of Bentlyl® with the calming effect of Quiactin®. Each tablet contains 20 mg. Bentlyl® and 300 mg. Quiactin®. The medication is intended to be effective in management of states in which there is a disturbance of gastrointestinal or other smooth muscle motility associated with emotional tension or anxiety.

The Present Study

Bentlyl with Quiactin® has been given to 208 patients (112 males and 96 females), varying in age from 18 to 79 years, who were seen in the author's private practice or gastroenterology. The usual physical, X-ray, and laboratory tests including G. I. series, gall bladder visualization, barium enema, sigmoidoscopic examination, stools, urine, Kahn, and blood counts were conducted to establish diagnosis in each case. The majority of patients suffered from functional bowel distress or duodenal ulcer either singly or with associated conditions such as pylorospasm, gallstones, pancreatitis, diverticula, or post-cholecystectomy syndrome (see Table 1).

Bentlyl with Quiactin® was prescribed in dosage

*Bentlyl and Quiactin are trademarks of The Wm. S. Merrell Company, Cincinnati 15, Ohio. Bentlyl is dicyclomine and Quiactin is oxanamide. Bentlyl with Quiactin is the combination product of these two drugs.

of one tablet three times daily for 50 patients, four times daily for 135 patients, three to four times daily for 21 patients, two to four times daily for one patient, and five times daily for one patient. The duration of drug therapy varied from three to 49 weeks; the average length of treatment for the series was 34 weeks. Bentyl with Quiactin® was given concurrently with many other agents, including tranquilizers, anti-cholinergics, laxatives, analgesics, and sedatives. In no instance was there evidence of drug incompatibility.

TABLE I
Response to Bentyl with Quiactin® — 208 Patients

Diagnosis	Good	Response Fair	Poor	No Relief
Functional bowel distress	74	12	1	4
Functional bowel distress with:				
pylorospasm	5	1		
gallstones	2	1		1
gallstones, post-cholecystectomy	1	1		
diverticula	2	1		
inactive duodenal ulcer	2			
prolapse of rectum	1			
gallbladder disease	1			
pernicious anemia	1			
duodenal diverticulum	1			
post-cholecystectomy syndrome				1
post-cholecystectomy syndrome with				
cholecystitis and cholelithiasis	1			
pancreatic insufficiency (?)	1			
hypoglycemia	1			
osteomyelitis	1			
anxiety state		1		
mild epilepsy		1		
Duodenal ulcer	38	4	1	
Duodenal ulcer with:				
functional bowel distress	2	1		
functional bowel distress and				
abdominal aneurysm			1	
gallstones and pylorospasm	1			
gastritis	1			
post-gastrectomy syndrome	1			
diverticulosis, diverticulitis		1		
Gallstones	9			
Ulcerative colitis	5	1		
Diverticulitis	4	1		
Pyloric ulcer	2	1		
Regional ileitis	2			
Antral ulcer	1			
Gastric ulcer		1		
Pre-pyloric ulcer	1	1		
Post-gastrectomy syndrome	1			
Cardiospasm	1			
Cardiospasm, duodenal diverticulosis,				
diverticulum	1			
Antral gastritis, diverticulitis	1			
Duodenitis	1			
Hiatal hernia, duodenitis, esophagitis		1		
Antral carcinoma				1
	168	30	3	7

Thirty-two patients in the series had already been treated with Quiactin® for an average of seven weeks at the time that Bentyl with Quiactin® was made available. We changed the patients' medication to the new compound because we felt that it would be more effective than Quiactin® alone in treating their conditions. Only one of these patients was returned to Quiactin® alone; he complained that Bentyl with Quiactin made him "jittery."

The general responses of the patients to Bentyl with Quiactin® were rated as good, fair, poor, or no relief from their complaints.

Results

Responses to the medication were good or fair

in 198 (95 per cent) of the 208 patients. Many of those not benefited were patients whose emotional problems have apparently prevented their response to all previous medication as well as to Bentyl with Quiactin®.

Most of the patients complained of the usual symptoms of gastrointestinal hypermotility; many of them offered multiple complaints. After taking Bentyl with Quiactin®, they reported responses subjectively. The number benefited (rated subjectively as good or fair) is tabulated and compared parenthetically to the total number of each symptom reported. The results were: anxiety, 196 (201); gas, 193 (200); apprehension, 169 (175); tension, 150 (155); abdominal pain, 116 (118); epigastric fullness and pressure, 111 (114); abdominal cramps, 66 (70); constipation, 30 (34); diarrhea, 30 (31); depression 15, (20); chest pain, nine (nine); vomiting, seven (nine); nausea, six (seven); and insomnia, five (six). Of a total of 1,149 various complaints only 46 were reported by patients as responding equivocally or not at all.

Side effects were very mild and infrequent. Five patients complained of dizziness; three of nausea; and two of feeling more nervous after the medication. There were single instances of abdominal discomfort, depression, blurred vision, tachycardia, insomnia, diarrhea, "jitteriness," dryness of mouth, rash, "burning inside and turning pink," and of medication simply "not agreeing." No abnormalities were revealed by periodic urinalyses, or determinations of the hemoglobin and white blood count.

Conclusion

Bentyl with Quiactin®, a new combination for gastrointestinal hypermotility, has been administered orally to 208 patients suffering from a variety of gastrointestinal complaints, especially functional bowel distress or duodenal ulcer, both singly and with associated conditions.

Each tablet contains 20 mg. Bentyl® and 300 mg. Quiactin®. The usual dose of one tablet was administered four times daily, often with other medications including tranquilizers, anticholinergic agents, laxatives, analgesics, and sedatives.

Of 208 patients, 198 (95 per cent) obtained good or fair relief and 10 reported poor or no relief. Associated symptoms such as anxiety, tension, apprehension, epigastric fullness, abdominal pain or cramps, and gas were greatly relieved by the combination. Twenty patients reported isolated side effects such as dizziness, nausea, increased nervousness, blurred vision, insomnia, diarrhea, "jitteriness," dryness of the mouth, and rash. Periodic urinalyses, hemoglobin determinations, and white blood counts revealed no abnormalities during drug therapy. The

new combination, Bentyl with Quiactin®, has provided maximum relief with minimum side effects to the great majority of patients suffering from complaints of gastroenterologic origin.

1467 Harper Street

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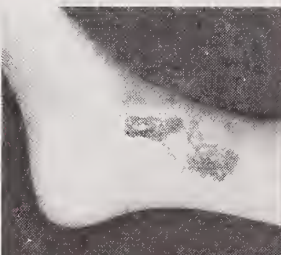
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PAGET'S DISEASE OF THE SKIN

(EXTRAMAMMARY)

Report of a case with review of literature.

Eladio Ochoa, M.D. and John T. Godwin, M.D., *Atlanta*

THE PURPOSE OF THIS paper is to report a case of Paget's disease arising in the skin of the anogenital region in a man and to review the literature pertaining to Paget's disease of the skin.

The historical evolution of the concept of Paget's disease may be traced from a lesion of the nipple described by John of Arderne in a priest of Calstone during the fourteenth century.⁹⁶

In 1840, Velpeau⁹⁷ described two cases of this condition in the breasts of two women who had "long since stopped nursing." Gintrac,³⁷ in 1856, recorded a case in the nipple of a man. In 1874, Sir James Paget⁷⁴ described a similar lesion in the breasts of 15 women and related it to carcinoma. He mentioned a lesion of the penis as an extramammary location for the lesion of the breast.

In 1917, Deaver and McFarland,¹⁸ in their book on breast diseases, recorded approximately 300 cases reported up to that time by other authors and stated that about 250 were probably Paget's disease. These two authors recorded 575 breast cases of their own, but accepted only one from this number as Paget's disease, for they believed it to be an extremely rare entity.

Weiner,⁹⁰ in 1937, reviewed the 57 cases of Paget's disease in extramammary locations reported to that date and accepted 15, added one new case, and considered 10 as possibly representing Paget's disease. Others have reviewed this material but have not concurred in the diagnosis of these cases (Stout,⁹² Pinkus, and Gould⁸⁰).

In 1955, Eisenberg and Theuerkauf²⁵ reviewed

the recorded cases of extramammary Paget's disease reported after Weiner, collected 18, and accepted 12 of these. In all, 80 cases have been reported in extramammary locations, the most recently reported being that by Rabson et al.,⁸² in April, 1958. This same case had been previously reported, however, by Schwarzmann⁸⁹ as a "Precancerous Perianal Lesion" in 1953.

Of the various reports of Paget's disease, 60 cases have been observed in men. Fourteen of these were in the breast; two were bilateral.

Although the lesion has been observed to have a wide anatomical distribution, including the eyelid,^{100,43} nose,⁸³ lips,¹⁰² back,⁶³ umbilicus,^{34,67} abdominal wall,^{26,88} and extremities,^{32,45,88} the predilection for the axilla and anogenital region is striking. Some of these cases were not confirmed histologically. A case with the histological features of Paget's disease has been recorded in the bladder and urethra.⁷³

Case Report

This 85 year-old white man was admitted to the hospital on October 21, 1957, for treatment of a chronically ulcerated lesion of the right inguinal region, which extended to the scrotum and anus. (Figure 1)

Pruritus was the chief complaint; it did not respond to ointments and X-irradiation. A biopsy specimen was examined prior to hospitalization and reported as Paget's disease.

On October 22, 1957, a segment of skin encompassing the grossly visible tumor was excised. (Figure 2) The wound healed and the patient was dis-

From the Department of Pathology, St. Joseph's Infirmary, Atlanta, Georgia.



Figure 1: Ulcerated lesion with disease extending along serpiginous discolored area.



Figure 2: Specimen from surgical excision.

charged on November 5, 1957. At the present time, there is no recurrence.

Pathology

The specimen of skin measured 12 x 6 cm. On sectioning the central portion, a hard, grayish-white mass, measuring 0.4 x 1 cm. was found, which was thought to represent the underlying primary tumor.

Microscopically, the primary lesion was a typical sweat-gland carcinoma (Figure 3) with areas resembling lobular carcinoma of the breast. (Figure 4) There was extension into and about the ducts and upward to the epidermis. The epidermis revealed the classical appearance of Paget's disease. (Figure 5) Mucicarmine stains were positive for intracytoplasmic mucus. This feature was also demonstrated in the biopsy specimen prior to excision. The margins of the surgical specimen were involved by Paget cells.

Discussion

Much of the early information about Paget's disease, including the description by Paget, was not confirmed by histological studies. This occasions

doubt as to the validity of some reports, though it may be difficult to decide which.

The questions: what is the Paget cell, where does it originate, and how does it reach the epidermis, are still not satisfactorily answered.

In 1876, Butlin¹⁰ gave the first histological description of Paget's disease. He did not find underlying carcinoma in the two cases studied and concluded that the skin lesion occurred first and was not necessarily malignant. Morris⁶⁹ concurred with Butlin in this opinion.

In 1890, Bowlby⁶ analyzed 13 cases of Paget's disease, which he believed originated in the "derma" as an inflammatory process that later might become malignant. Other observers^{5,9,52,57} had similar opinions. Bowlby also believed that Paget cells might occur in other conditions, being one of the first observers to doubt the specificity of Paget cells.

In 1889, Darier¹⁶ advanced the theory of psorosperms (fungus), which appealed to several authors.^{59,83,101} In 1900, Darier¹⁷ described Paget's disease in extramammary locations and postulated it as representing a dyskeratosis. This concept was

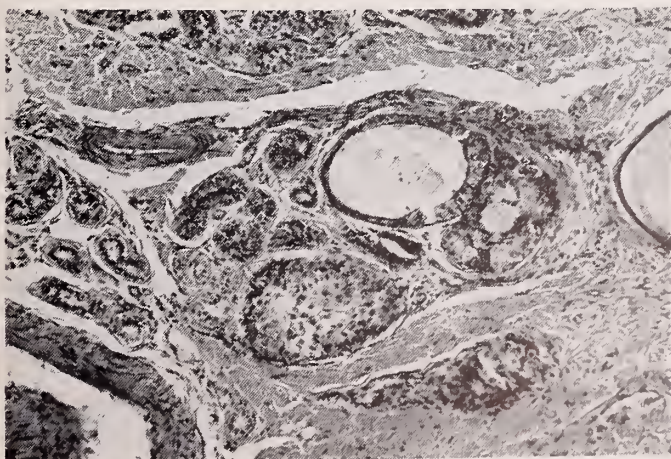


Figure 3: Photomicrograph of carcinoma apparently arising in sweat gland.

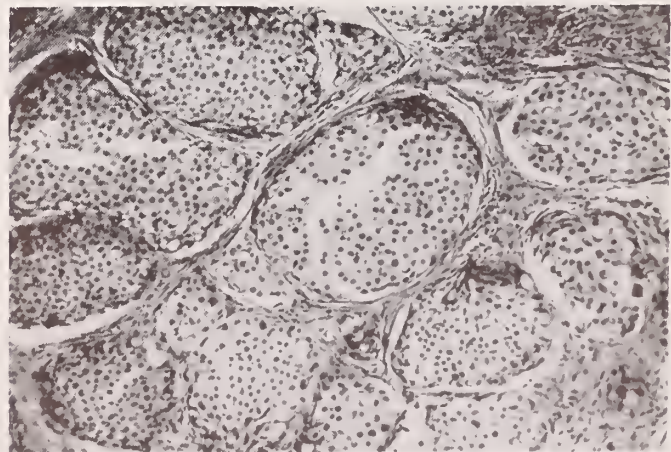


Figure 4: Photomicrograph showing areas simulating lobular carcinoma of breast.

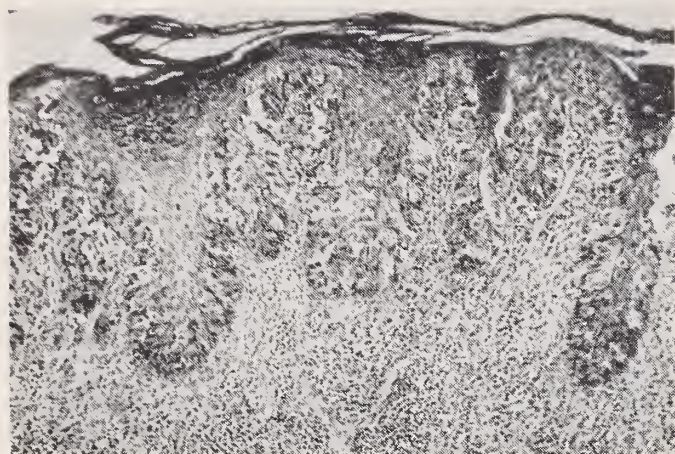


Figure 5: Photomicrograph of epidermis containing typical appearing Paget's cell.

supported by others^{5,52,72,85} Darier believed the dyskeratotic lesion could give rise to occasional malignant growths, indicating the precancerous nature of the dyskeratosis, and this subsequently was supported by many authors,^{52,57,85,95} but strongly opposed by Pautrier et al,⁷⁶ who believed the lesions to be malignant from the outset.

Reported cases of long duration, not histologically proved, appear to support the benign or occasional precancerous nature of the lesion.^{51,66,71,94}

Karg⁵⁴ suspected Paget's disease of being a malignant epidermal lesion initially, and he was supported in this by several authors.^{7,8,103} He believed the lesion began in the prickle cells and invaded upward and downward and that stages of *transition* could be traced from the normal prickle cells of the epidermis to Paget cells. Ormsby and Montgomery,⁷² and Montgomery⁶⁸ also saw these transitions.

The origin of Paget cells in mammary gland carcinoma was probably first suspected by Thin⁹³ in 1881 and later supported by many.^{20,23,50,61,77,90,91} In a series of seven cases, Dockerty and Harrington¹⁹ found the histological pattern of Paget's disease without clinical manifestations.

Handley⁴⁴ believed that carcinoma of the breast preceded the skin changes and that the epidermal response was due to lymphatic-vessel obstruction by cancer cells.

The apparent absence of underlying carcinoma does not rule out the mammary gland origin of Paget cells because this type of carcinoma can be overlooked⁷⁷ or it may remain "quarantined by fibrous tissue" for relatively long periods of time.¹³

Karsner,⁵³ however, admits that sometimes underlying carcinoma is not found. Ackerman¹ also shares this view.

In 1888, Crocker¹⁴ stated his belief in the origin of Paget cells in sweat glands and that the cells are

malignant at the time of origin. This has been accepted by others.^{31,39,47,50,55,61,75,76,81,91,99}

Arzt and Kren⁴ and others^{11,21,27,62} had a concept of a "Morbus Paget Simplex" and a "Morbus Paget Metastaticus" of epidermal and extraepidermal origin respectively. The former was not necessarily malignant, but the latter was always metastatic carcinoma. Arzt and Kren reported 10 cases in the perianal skin associated with carcinoma of the rectum. Pinkus and Gould⁸⁰ made similar observations and suggested that Paget's disease may appear also in mucocutaneous junctions. Green and Epstein⁴⁰ and Pearson and McArt⁷⁸ did not accept this concept. There is, however, the constant relationship of the two different epithelia involved in Paget's disease, such as mucocutaneous junction of the perianal region, mammary ducts and skin of nipple, sweat glands and skin, and prostatic ducts and urinary bladder.^{60,73}

Positive mucicarmine stains support the glandular origin of Paget cells.^{20,60,86,99} The normal mammary gland is poor in mucous content, though mucous-containing cells are present in about 65 per cent of cases of breast cancer (Frantz³⁵ and Godwin³⁸).

Helwig⁴⁶ believes that the skin of the regions in which Paget's disease occurs may retain the potentiality to produce mucus. Mucous-producing cells are present in the transitional-cell epithelium of the normal anorectal junction.⁴¹

The presence of Paget cells in the epidermis simultaneously^{31,41} with gland ducts demonstrated in *serial-section studies*²⁸ supports the unique origin of the deep and superficial lesions.

Paget cells contain glycogen and the mammary gland is thought not to contain this substance.³ Lubarsh and Gierke⁶⁴ mention that glycogen may be present in mammary carcinoma.

Fisher and Beyer²⁹ found that the acid Schiff stain is positive in metastatic cells in the epidermis, normal sweat-gland cells, sweat-gland carcinoma, and in occasional normal epidermal cells. They proved that the reaction in the normal epidermal cells is due to glycogen.

The lack of prickles of the Paget cell suggests an extra-epidermal origin^{76,77} as well as does its peculiar shape. Deaver and McFarland¹⁸ believe the cell loses its prickles during the same degenerative process that alters its form.

Difficulty Distinguishing Cases from Melanoma

Certain authors have experienced difficulty in distinguishing certain cases from melanoma,⁹² Bowen's disease,^{2,62} erythroplasia of Queyrat⁸⁸ with several concluding that some of these entities are different

manifestations of the same process⁸⁸ or doubt the existence of extramammary Paget's disease^{2,36,68} at all. According to Watkins and McDonald,⁹⁸ Paget's disease is an in situ squamous-cell carcinoma of the skin of the nipple, always associated with an underlying intraductal carcinoma. Others admit a clear difference between Paget's and Bowen's diseases.^{47,49,65}

It has been noted that Paget cells do not keratinize¹ and do not invade the corium.⁶¹

Grynfeldt, Margarot, and Guibert⁴² recorded a case in which the skin of the nipple and areola and the sweat glands were involved by carcinoma and the *lactiferous* ducts uninvolved.

Cheatle and Cutler¹² serially sectioned material from 17 cases of Paget's disease and, from the information, concluded that Paget cells have a multicentric origin, i.e., epidermis, lactiferous ducts, duct orifices, and are induced by the same agent, which may have a particular affinity for breast epithelium and may be "blood borne." This theory is adhered to by Satani,⁸⁷ Rubenstein,⁸⁵ and Casper¹¹ and others.²²

Other authors have related the disease to hormonal disturbances¹⁵ or consider it a familial disease⁵⁸ or a manifestation of syphilis.³³

Paget cells may reach the epidermis by continuity via ducts (intraepithelial spread)^{24,30,48,49,60,70,73,79} or by metastasis.⁸⁴

The literature reviewed covering the past 75 years gives many explanations of Paget's disease as indicated, many contradictory, but interesting and convincing.

Present day authors tend to accept a sweat gland or mammary gland carcinoma origin for Paget cells. This is in accord with the common embryogenic origin of the two glands⁵⁶ and the histological morphology of the lesion. They also tend to accept the intraepithelial spread as the most probable mode of expansion to the epidermis and the wide extension in the epithelium.

Sweat-gland Origin of Tumor

PAS and mucicarmine stains in the case reported here support the sweat gland origin of the tumor. The extension of tumor cells along the duct epithelium to, and including, the skin indicates direct extension or progressive changes of contiguous epithelium as an area carcinogen or the neoplastic cells exert their effects on normal cells. The epidermal component extended several centimeters beyond the area overlying the sweat gland carcinoma.

Summary

A case of classical Paget's disease, occurring in the anogenital region of a man, is reported together

with a review of the literature for the past 75 years.

265 Ivy Street, N.E.

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1959-60 CALENDAR OF MEETINGS

State

May 1-4, 1960—Annual Session, Medical Association of Georgia, Municipal Auditorium, Columbus.

Dec. 1-3—Medical College of Ga. and Medical College of Ga. Foundation's Postgraduate Course, Augusta.

Dec. 3-4—Emory University School of Medicine, Postgraduate Course, Grady Memorial Hospital, Atlanta.

Regional

Jan. 21-23—Sectional Meeting of the American College of Surgeons, Brown Hotel, Louisville, Ky.

Mar. 7-10—New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.

National

Nov. 29-30—American College of Chest Physicians, Dallas, Tex.

Nov. 29-Dec. 2—National Society for Crippled Children and Adults, Chicago, Ill.

Dec. 1-4—AMA Clinical Meeting, Dallas, Texas.

Dec. 5-10—American Academy of Dermatology and Syphilology, Palmer House, Chicago, Ill.

Dec. 11—American Rheumatism Association, Henry Ford Hospital, Detroit, Mich.

Jan. 11-13—American Academy of Allergy, Hollywood Beach Hotel, Hollywood-by-the-Sea, Fla.

Feb. 3-6—American College of Radiology, Roosevelt Hotel, New Orleans, La.

Mar. 21-24—AAGP, Annual Scientific Assembly, Convention Hall, Philadelphia, Pa.

SURGICAL ASPECTS OF BILIARY TRACT DISEASE

By using operative cholangiography as an

adjunct, a number of unnecessary common duct

explorations can be avoided.

BILIARY TRACT DISEASE OCCURS often and presents many interesting and difficult problems. Therefore, it may be worthwhile occasionally to review surgical experiences in the light of these problems and current attempts at solution.

Quite frequently one is asked "is it necessary to remove gall stones" and "if my gall bladder is removed will my digestion be better or worse?" Apparently from the confusion that exists, not even all physicians are in agreement on these subjects. The fact that some individuals continue to have digestive or upper abdominal symptoms after cholecystectomy concerns us all and leads the surgeon to seek the causes and possible prevention of such difficulties.¹

The present paper represents a review of 150 consecutive cases of biliary tract disease operated upon during the years 1946 through 1958. In this group women outnumbered men approximately six to one and the age at operation varied from 19 to 82.

FIGURE I
Biliary Tract Operations 1946-1958

Female 128	Male 22	Total cases 150
<i>Age</i>		
18-29		13
30-39		24
40-49		28
50-59		45
60-69		28
70-82		12

By far the most common symptom was epigastric or right upper quadrant pain, usually intermittent

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in nature and brought on by food. Sometimes, however, the pain was relieved by alkalies and food, or at times was not distinguishable from angina pectoris. Often a sense of fullness, gas, sour stomach after eating, and a tendency toward constipation, led to X-rays and a diagnosis.

FIGURE II
Presenting Symptom

Pain and indigestion	112
Jaundice	26
No symptoms	3
Stones discovered at pelvic surgery .	9

Pathologically the majority of these cases had chronic calculous cholecystitis. Acute cholecystitis was found 23 times, common duct obstruction in 32, acute hemorrhagic pancreatitis in four, and chronic pancreatitis in three others. It was noted that peptic ulcer past or present coexisted with cholelithiasis in 13 instances, arteriosclerotic heart disease in eight, cirrhosis of the liver in eight, and hiatus hernia in seven.

Diagnosis

In a few cases the intravenous Cholangraffin test was used in the acutely ill patient, or to visualize the common duct after previous removal of the gall bladder. This can occasionally be a valuable tool as is probably the recently advocated oral cholangiogram.⁸ However, the tests are time consuming and the details of the common duct not sharp enough to

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make these routine procedures so far. The regular Graham-Cole test has proved very reliable and in every instance where a repeated failure to visualize was followed by operation, a diseased gall bladder was found. The presence of jaundice usually prevents X-ray diagnosis and requires blood, urine, and stool studies to determine liver function and differentiate between medical and surgical illness.

Complications of gall stones such as acute cholecystitis, obstructive jaundice, cholangitis, biliary cirrhosis, and pancreatitis were seen in over one-third of the cases. These are serious, unpredictable consequences occurring often in these patients half of whom were over 50 years of age. Fortunately, there was no operative mortality. However, one patient with known coronary artery disease and cholelithiasis had a temporary cardiac arrest during surgery. Because of the fairly high rate of unpreventable complications as the disease progresses, it would seem advisable to perform cholecystectomy as an elective procedure in all patients who are discovered to have stones and in whom the operative risk is not prohibitive.²

Technique of Operation

Cholecystectomy is preferred over cholecystostomy because of the frequency of recurrence of stones in the latter. Two of these were such cases. However, in the acutely ill poor risk patient, especially where edema and inflammation extend to the common duct and pancreas, cholecystostomy may be all that is indicated, reserving the more definitive procedure for a safer time.

At surgery, it is very important to visualize the duct area and identify each structure ligated. Usually the cystic duct and artery are ligated separately and the gall bladder removed from below. If inflammation is present it often is safer to dissect the gall bladder from fundus downward. In one case with large impacted cystic duct stone a small common duct was inadvertently divided. This was repaired at once end to end over the arm of a small T tube which was left in place six weeks and the patient has remained well. Several sphincterotomies were done transduodenally and the long arm T tube used in these. However with routine duct exploration and adequate dilation of the sphincter to 8 to 10 mm. the regular short arm T tube is quite effective, removing it one week later if the repeat cholangiogram is negative. End to end repair of the common duct or choledochoduodenostomy are believed to be the best procedure for stricture of the duct whenever such repairs are possible.

No hard and fast rule was followed in regard to

acute cholecystitis. Obviously, if the disease is progressing, surgery must be undertaken. Ideally it is best to operate at a time when inflammation is at a minimum and this was done wherever possible. Four acutely ill patients, three female and one male, presented with acute hemorrhagic pancreatitis, common duct stones, and acute cholecystitis. Emergency surgery consisting of cholecystectomy and choledochostomy was done in all with recovery but only after protracted courses and in two instances secondary drainage operations.

FIGURE III
Operation Performed

Cholecystectomy and choledochostomy	48
Cholecystectomy alone	99
Choledochostomy alone (previous surgery)	2
Cholecystostomy	1

In the first half of the series, two cases having cholecystectomy alone had attacks of postoperative pain which suggested retained common duct stones. Two had one transitory episode of jaundice postoperatively. Another jaundiced patient had a choledochostomy and on repeat cholangiogram was found to have a retained stone, which required a second operation. These cases call attention to the fact that one of the most important aims of surgical treatment is to discover and correct any common duct pathology at the original operation.¹⁰

FIGURE IV
Common Duct Operations in 150 Cases

Duct explored	50
Obstruction found	32
Negative	18
Stones found no jaundice	6

In this series one-third of the cases had duct exploration and of these two-thirds were found to be positive and one-third were negative. The incidence of common duct stone without previous jaundice was six cases or 18 per cent of the positive ducts.

Various authors give different indications for common duct exploration and different series show different series show different incidences for this procedure. In general the indications usually given are: (1) jaundice, (2) dilation or thickening of the cystic or common duct, (3) small stones in the gall bladder, (4) palpable stones in common duct, (5) pancreatitis or induration of the head of pancreas, (6) enlargement, induration or cirrhosis of the liver, (7) contracted gall bladder, and (8) muddy bile in cystic or common duct.^{3,4} If the surgeon faithfully follows these indications, he will perform many negative explorations with increased morbidity, discomfort, and expense to the patient. Rarely, he may over-

look an unsuspected stone when none of these indications are present.¹⁰

Operative Cholangiography

Operative cholangiography was begun in 1951 in an attempt to get more direct indication at the operating table for duct exploration. This procedure dates back to 1936 in this country when Robins and Hermanson³ reported their early results. Papers by Doubilet and Mulholland⁵ in 1948 on "Recurrent Acute Pancreatitis" and Carter and Gillette⁶ in 1950 on "Immediate Cholangiography" stimulated this trial. Early results reported in 1955, seemed to prove it a worthwhile procedure and so it was continued to be used.

The technique is a modification of that given by Carter and Gillette. In brief, it consists of removing the diseased gall bladder and passing a small catheter into the common duct through the stump of the cystic duct. This is lightly tied in place. With the film placed in a tunnel under the patient, who is slightly tilted to his right, and the X-ray tube overhead, 15-20 cc. of a solution of 25 per cent diodrast is injected into the common duct, the operator being very careful not to introduce air bubbles. As the injection is made the anesthetist produces apnea and controls respiration long enough for an adequate X-ray exposure.. The film is developed at once and read in the operating room by the surgeon, with the aid of the radiologist if available.

By good teamwork this procedure only adds a few minutes to a cholecystectomy. With it we learn several things: (1) the degree of common duct dilation and obstruction, if present, (2) the presence of stones in the common or hepatic ducts, and (3) whether there is a reflux into the pancreatic duct suggesting a possible cause for chronic or acute recurring pancreatitis.

FIGURE V
Operative Cholangiography in 133 Cases

Procedure failed	5
X-ray positive or suspicious	23
Findings confirmed	18
X-ray picture negative	49
Duct explored (small stones)	4
In these stones found	0
TOTAL	77

False positive	5	False negative	0
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From this experience, numbering 77 operative cholangiograms in 133 cases, the procedure is a practical one which can be done safely and successfully. When indicated it gives much valuable information. However, it increases the operating time, requires considerable attention to detail and carries

with it some extra exposure to irradiation. For these reasons it is not advocated as a routine in all cholecystectomies regardless of the clinical features. It is now being employed by us in approximately 60 per cent of cases.

By using this as an adjunct, a number of unnecessary common duct explorations can be avoided, particularly in cases with small stones in the gall bladder without jaundice. In four such instances the cholangiogram was negative but the common duct was explored anyway. All these ducts were negative.

Also, it has been stated that 35 per cent of patients having common duct stones are not jaundiced,⁷ and in this series there were six such cases or 18 per cent of positive ducts. In these a cholangiogram will often indicate the need of exploration.

The questions have been asked "why do a cholangiogram when, because of jaundice or other indication, the surgeon plans a duct exploration anyway? Why not wait and do one after the T tube has been inserted?" From this experience the cholangiogram is best done prior to duct exploration as it may show stones in the hepatic ducts as well as details of the obstruction, and configuration of the common duct. This information is of great aid in exploring the common duct and not then overlooking pathology.³ When the X-ray is made after the duct exploration, it is difficult to get a good picture due to leakage around the tube and also spasm of the lower end of the duct.

Cholangiograms are then indicated in all patients in whom common duct pathology is suspected. They are not indicated in patients with single, large or faceted stones with small ducts and no history of jaundice. Especially is this true in the older patient in whom the possible benefit of doing a cholangiogram must be weighed against the hazard of prolonging the operation.

Results of Surgery

The first 72 cases 1946-1954 were the subject of a follow-up survey.

FIGURE VI

Cases followed 1946-54	72
Followed	62
Lost to follow-up	10
Post operative pain	6
Post operative jaundice	2
Digestion better	38
Digestion worse	1
Digestion same	15

From these the clinical impression is gained that cholecystectomy alone or with choledochostomy if indicated is effective in relieving the attacks of pain

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and preventing recurrent jaundice. Usually the digestion is reported as better particularly if attacks of colic have been present. However, it was noted that the general digestive pattern often remains the same and those whose chief complaint is dyspepsia often continue to complain of this symptom post operatively. In recent years the fairly frequent co-existence of hiatus hernia and cholelithiasis has been noted and this may explain some of the failures of cholecystectomy to relieve symptoms when these hernias are not repaired.⁹ A definite impression has been gained that results are better since the use of cholangiography as outlined above.

Summary and Conclusions

One hundred and fifty consecutive operations for biliary tract disease have been reviewed. From this material one can recommend removal of all diseased gall bladders with or without gall stones except in those patients in whom the operative risk is prohibitive. Careful attention to discover and correct

common duct pathology including the frequent use of operative cholangiography will greatly improve post operative results.

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DR. MACKINNON ARRIVES AS MILLEDGEVILLE CHIEF

MILLEDGEVILLE STATE HOSPITAL welcomed its new superintendent, September 17, as he announced that his major interest is in providing the best possible psychiatric care with present facilities and in working toward improvements throughout the Hospital.

Dr. MacKinnon, who brings to the Hospital the benefit of nearly 40 years of experience in medicine, psychiatry, teaching, and administration, accepted the position several weeks ago. He resigned as professor of psychiatry at Columbia University College of Physicians and Surgeons in order to come to Georgia.

Dr. John Venable, who has served as director of the Hospital since its transfer in April from the Department of Public Welfare to the Department of Public Health, remained at the Hospital for several days with Dr. MacKinnon. He is scheduled to become Director of the Department of Health in January following the retirement of Dr. Thomas F. Sellers, who will become director-emeritus.

In an interview with news reporters, Dr. MacKinnon said the Hospital has immediate plans for a program to offer three months of psychiatric training to medical students from Emory University and the University of Georgia. This will be developed into a three-year accredited program for training psychiatrists to serve at the Hospital.

Further training of the Hospital's present staff was also described by Dr. MacKinnon, who said it would include all levels of the staff from the attendants to the psychiatrists.

He predicted no major alterations at the Hospital but

said improvements would be made quietly and easily. Dr. MacKinnon endorsed the improvements and plans already made at the Hospital by Dr. Venable and the Department of Health and said he would continue to build on the foundation established by the Department.

He said he did not plan to make his position as superintendent a "tough" job but hoped to work at it "easily, gracefully, pleasantly, and enjoyably."

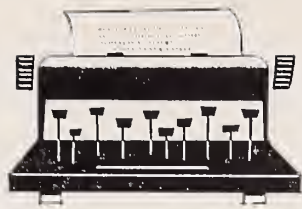
Dr. MacKinnon was born in Boston, Massachusetts, in 1898. He received his M.D. degree at Tufts in 1920. and specialized in psychiatry. He practiced for several years in Maine, Ohio, and New York. In his teaching experience, he was assistant professor of psychiatry at Columbia University College of Physicians and Surgeons, in 1938-39; associate professor in 1948-54 and professor since 1954. In his professional experience he was principal clinical psychiatrist at the New York Psychiatric Institute in 1947, and director in 1948. He has been an attending psychiatrist at Columbia University Presbyterian Hospital, New York City, and a consultant at the U. S. Naval Hospital, St. Albans, New York.

He is author of several books and scientific articles on psychiatry.

Dr. and Mrs. MacKinnon will occupy the superintendent's residence at Milledgeville. They have one son, Dr. Roger Alan MacKinnon, Chief of Psychiatric Division, Vanderbilt Clinic, Columbia University Presbyterian Hospital; and a daughter, Mrs. James Montague, Durham, North Carolina.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Avant, Earl S.	781 Spring St., Macon	Active	Bibb
Beall, James Harvey	Carrollton	Active	Carroll-Douglas-Haralson
Bennett, Claude E.	Toccoa Clinic Medical Association, Toccoa	Active	Stephens
Brown, Dwight J., Jr.	10 Professional Bldg., Brunswick	Active	Glynn
Birch, Herbert Warren	410 Glenn Bldg., Butler St., Atlanta	Active	Fulton
Carter, Leon, Jr.	The Decatur Clinic, 231 E. Ponce de Leon Ave., Decatur	Active	DeKalb
Cohen, Sheldon Bradley	Suite 1203 Medical Arts Bldg., Atlanta	Active	Fulton
Cook, Ernest Lawrence	Doctors Building, Thomson	Active	McDuffie
Domingos, Wm. Robert	654 First Street, Macon	Active	Bibb
Erbele, Leo Albert	Macon Hospital Laboratory, Macon	Active	Bibb
Evans, Wm. Walker	Veterans Adm. Reg. Off., 441-49 W. Peachtree St., Atlanta	Active	Fulton
Fisher, J. Edward	Georgia Baptist Hospital, Atlanta	DE 2	Fulton
Gussack, Harold A.	478 Peachtree St., Atlanta	Active	Fulton
Innes, Robert C.	104 E. Taylor St., Savannah	Active	Ga. Medical Society
Keener, Ellis Barlow	Emory University Clinic, Atlanta	Active	Fulton
Kinard, Garland E.	16 Euclid Ave., Chickamauga	Active	Walker, Catoosa. Dade
Morgan, Harvey Vaughn	102 East Gwinnett St., Savannah	Active	Ga. Medical Society
Newton, William Ross	3741 Houston Ave., Macon	Active	Bibb
Raybourne, Jack E.	781 Spring St., Macon	Active	Bibb
Schatten, Wm. Eugene	710 Peachtree St., Atlanta	Active	Fulton
Smir, Robert Hudson	Talmadge Hospital, Augusta	Active	Richmond
Stephenson, Barbara A.	Emory University Clinic, Pediatric Section, Atlanta	Active	Fulton
Waters, William C., III	Grady Memorial Hospital, 80 Butler St., Atlanta	DE 2	Fulton



editorials

What the Facts Show

REVOLUTIONARY ADVANCES IN medicine have opened entirely new approaches to curing illness. Since 1900, better medical care has helped to increase the life expectancy of the average American by more than 20 years.

Obviously, this is very real progress. In big measure, this has been made possible by the opportunity of American physicians to work in freedom—as individual to individual, as physician to patient, free of governmental dictation.

When this opportunity to work in freedom is restricted or abolished, the American people suffer, and American medical progress suffers.

Yet there is now under consideration in Washington a bill that would undermine this freedom and destroy the voluntary progress that has achieved so much for our citizens. This bill (H.R. 4700), sponsored by U. S. Rep. A. J. Forand of Rhode Island, would finance—through higher social security taxes—hospital, surgical and nursing home treatment for some 16 million persons eligible for social security payments.

There are many reasons why this legislation should be decisively defeated.

The bill—a political approach to a health problem developed by non-medical people—would put the Federal Government into an area of health care in which it is badly equipped to function; it would cripple and gradually replace voluntary health insurance; it would jeopardize the traditional doctor-patient relationship; it would put an agency of the Federal Government in the role of setting fees for physicians and charges for hospitals and nursing homes; it would mean that an agency of the Federal Government would administer the program and stipulate the type of care to be provided; it would

swing open the gates to the socialization of medicine.

Moreover, the bill would be staggeringly expensive. Authoritative estimates indicate the cost would be in the neighborhood of \$2 billion for the first and second years. Yet this would be only the beginning. The costs would keep on rising. Everyone who pays social security taxes would be forced to help foot the bill. This means paychecks would keep on dwindling.

But, most important of all, the bill would reduce the quality of medical care. It would result in poorer—not better—medical care for the people of this country.

The truth is that the health requirements of our citizens—the elder citizens certainly included—can never be met through inflexible methods made compulsory by the Federal Government.

What do the facts show? The facts show that private, voluntary methods are working and working well. At this time about 43 per cent of our citizens over 65 are covered by private health insurance. Much of this growth has occurred within the past few years. Certainly, there is every sign that this growth will continue. Sound estimates indicate that 75 per cent of our elder citizens who need and want such protection will be covered by voluntary health insurance by 1965 and 90 per cent by 1970.

Actually, that is only a small part of the story of the voluntary progress of our elder citizens in recent years. Throughout the United States, retirement villages, new nursing homes, chronic disease care centers, home care programs, recreational facilities and research projects have been established, and many, many more are on the way.

All this is good. Still, it is essential that American

medicine does not attempt to relax and rest upon its oars. There is still work to be done. It is vital that more and more physicians take a role of leadership in their own communities in expanding and improving practical programs that will help the aged to help themselves. It is vital that physicians throw their weight behind such programs as home-maker services, progressive patient care, high-standard nursing home care, and so on. It is vital

that physicians encourage their patients to carry Blue Cross, Blue Shield or commercial insurance.

And, no doubt about it, it is vital that physicians speak out their convictions. The Forand bill is compulsory national health insurance. It is bad medicine—bad for the nation and bad for the nation's health. It is the responsibility of physicians to help to make this fact plain—so plain that no one can fail to understand.

Governor's Commission on Aging Activated

ON APRIL 2, 1959, an Interdepartmental Council on Gerontology was created by the executive order of the Honorable S. Ernest Vandiver, Governor of Georgia. This Council was composed of designated members of the following state departments: health, education, welfare, vocational rehabilitation, and labor. In this intergovernmental council was vested the authority "to coordinate the efforts of the various state programs concerning the aged in the health, education, welfare, vocational rehabilitation, and labor departments of State Government; to disseminate information gained through research and study to local government and civic groups interested in the needs and problems of our elder citizens and to administer the funds which may be made available to the state by the Federal government in connection therewith."

Representatives of both the Medical Association of Georgia and the Georgia Joint Council to Improve the Health Care of the Aged (Medical Association of Georgia, Georgia Hospital Association, Georgia Dental Association, and the Georgia Nursing Home Association) felt that the needs of our senior citizens might be met more comprehensively if equal representation of citizen groups and governmental groups existed. Furthermore, it was felt strongly that the responsibility for such a program and the eventual White House Conference planning should rest with a group representing all walks of life interested in the aging problem. While the immediate plans were pointed toward the White House

Conference, the ultimate goal was felt to be broader. Planning toward a continued and lasting effort to help the elder citizens by the establishment of a Governor's Commission was urged. These attitudes were discussed with the Governor and with the members of the Interdepartmental Council on Gerontology. As a direct result of this, the Governor abolished the Interdepartmental Council on Gerontology, created an Interdepartmental Committee to deal with the State's responsibilities, and in September, 1959, established the Governor's Commission on Aging.

The major purveyors of health care were well represented in the appointments. Dr. John Tyler Mauldin was designated to represent the State at Large and also to act as chairman of the commission. The Medical Association of Georgia's designee was Dr. John S. Atwater, chairman of the Medical Association of Georgia's special committee on Health Care of the Aged. Representatives of all the component units of the Georgia Joint Council to Improve the Health Care of the Aged were appointed.

The Committee on Aging of the American Medical Association has suggested a six point program in approaching the problem of aging. These points are: (1) stimulation of a realistic attitude toward aging by all people, (2) promotion of health maintenance programs and wider use of restorative and rehabilitative services, (3) extension of effective methods of financing health care for the aged, (4) expansion of skilled-personnel training programs and improve-

ment of medical and related facilities for older people, (5) amplification of medical and socioeconomic research in problems of the aging, and (6) leadership and the cooperation in community programs for senior citizens.

Through the medium of the Georgia Joint Council and the Governor's Commission on Aging it is

felt that the Medical Association of Georgia and its constituent members are now in a position to render real service to the people of Georgia.

The Medical Association of Georgia is grateful and feels an indebtedness toward Governor Vandiver for his wonderful cooperation and interest in getting this project off to a running start.

John S. Atwater, M.D.

A Clinical Approach to the Management of Sick Cell Anemia

THERE APPEARED IN THE Archives of Internal Medicine, in 1910, an article by J. B. Herrick entitled "Peculiar Elongated and Sick-shaped Red Corpuscles in a Case of Severe Anemia." In this article Herrick published his description of the cellular anomaly in sickle cell disease. In 1917 Emmel noted the first dynamics of the sickling mechanism. Years later Scriver and Waugh showed that the number of sickle cells increased as oxygen diminished and carbon dioxide accumulated during venous stasis in an extremity. Sydenstricker, who probably did more than any other to alert practitioners to the clinical entity of sickle cell disease, observed that sickling was accompanied by a concentration of hemoglobin and an increased plasticity of the corpuscles.

Pauling, in 1949, demonstrated by free electrophoresis that hemoglobin from patients with sickle cell anemia differed from the normal in its electrophoretic mobility. Singer demonstrated that sickling with the resultant formation of tactoids, probably the basic architectural structure of the crystallized hemoglobin, was a specific characteristic of reduced S-hemoglobin.

The conditions required for the sickling of erythrocytes and the factors known to influence or affect the sickling process are fairly well established. Evidence indicates that when susceptible cells are deprived of oxygen at low temperatures sickling does not occur, that erythrocytes of sickle cell anemia

patients that contain a high proportion of fetal hemoglobin are relatively resistant to sickling, and that factors such as erythrostasis and hemoconcentration do play a significant role in the progressive phenomenon of sickling.

Recently the possibility that carbon anhydrase activity is necessary for sickling has been investigated. As a result of these preliminary reports clinical trials are now underway within the state for evaluation of a carbonic anhydrase inhibitor in the management of sickle cell anemia patients. From such clinical studies thus far, one is impressed with the apparent beneficial effects of these drugs in the long term prophylactic management of the sickle cell anemia patient. There have been no undesirable side effects of the drug as administered thus far.

Formerly in the management of the child with sickle cell anemia the use of prophylactic antibiotics had seemed to play only a minor role in the prevention of the hemolytic or the aregenerative crisis. This was probably due to the prevalence of viral infections in the pediatric age group and probably to a lesser extent the development of drug resistant organisms.

In the long term management of the sickle cell anemia patient the judicious use of a carbonic anhydrase inhibiting drug has appeared to play a favorable role in preventing these crises.

CONTINUOUS FIGHT AGAINST FORAND BILL URGED

WITH THE ADJOURNMENT of the 86th Congress in mid-September, the medical profession is given a breathing spell in which to regroup our forces and plan our campaign for defeating the efforts directed toward the overthrow of our form of medical practice.

A preliminary skirmish in the battle of state medicine vs. the private practice of medicine occurred during the hearings on the Forand bill (H. R. 4-700) before the House Ways and Means Committee in August. This testimony drew the battle lines, but produced no action by the House Committee. On one side of the front were aligned the physicians, represented by the AMA, state medical societies, American Academy of General Practice, the American Hospital Association, American Pharmaceutical Association, Health Insurance Industries, "the Blues," the U. S. Chamber of Commerce, Nursing Homes, American Dental Association, American Farm Bureau, and finally Mr. Fleming, Secretary of the Department of Health, Education, and Welfare. These individuals and organizations firmly opposed this socialistic bill.

Proponents of the Forand bill testifying were organized labor, the American Nurses Association, Physician's Forum, social service organizations, welfare agencies, all who have been consistently in favor of the complete socialization of medicine.

The AMA, the Council and Office of MAG, and many of the doctors of Georgia recognize the seriousness of the problem and are organizing for an all out fight against the Forand bill at the next session of Congress, when the battle will actually be joined.

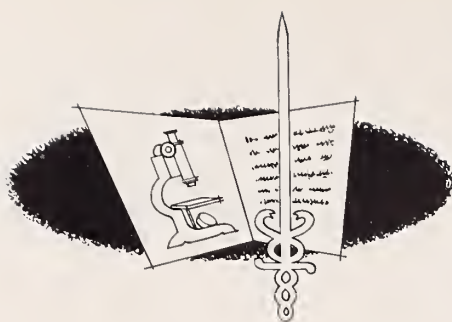
It is imperative that every doctor in the State of Georgia support and actively enter this fight against socialized medicine, not only by personally backing the call for help made by AMA and MAG, but also by talking to organizations, individuals, and patients to make them see the ills in medical care that will inevitably result should such legislation be passed.



Luther H. Wolff

LUTHER H. WOLFF, M.D.,

President, Medical Association of Georgia



cancer page

MULTIPLE MALIGNANCY

Thomas Harrold, M.D., *Macon*

IT HAS BEEN RECOGNIZED for a long time that a person who has had one malignant tumor is more likely to have a second one than is a person who has never had the first tumor. This second tumor may occur in the same organ, such as the colon, or in some entirely unrelated part of the body. In one large series of autopsies done on patients dying of cancer, four per cent were found to have more than one primary tumor. It is interesting to speculate on just why this should be true. Whether cancer is caused by a virus or is due to some hormonal dysfunction or other etiological agent, it is apparent that the conditions suitable for the growth of tumors are more favorable in some people than in others.

It also appears that some individuals have a greater resistance to cancer than others. Therefore, although a person who has survived one cancer is more likely to have a second one, it is also true that by virtue of having survived the first one he has demonstrated resistance and may also survive the second or subsequent cancers.

During the past year in a consecutive, but unselected, group of 111 patients who returned for routine follow-up examination, eight instances of multiple malignancy were observed. All of these were apparently well of their first malignancy for five years or longer. It will be noted that one patient has survived three major malignant tumors.

Age	Year	First Malignancy
48	1932	Breast—Paget's disease (First Case)
75	1951	Breast—Simple mastectomy (Second Case)
43	1947	Breast—Radical mastectomy (Third Case)

64	1944	Breast—Radical mastectomy (Fourth Case)
65	1947	Cervix uteri—Radiation (Fifth Case)
62	1953	Fundus uteri—Hysterectomy (Sixth Case)
60	1951	Larynx—Laryngectomy (Seventh Case)
52	1945	Colon—Resection (Eighth Case)

Age	Year	Second Malignancy
51	1935	Breast—Paget's disease (First Case)
75	1951	Breast—Simple mastectomy (Second Case)
45	1949	Breast—Radical mastectomy (Third Case)
78	1958	Colon—Resection (Fourth Case)
77	1958	Hard palate—Radiation (Fifth Case)
62	1953	Malignant carcinoid intestine (Sixth Case)
63	1954	Rectum—abdomino-perineal resection (Seventh Case)
57	1950	Cervix—Radiation (Eighth Case)

Age	Year	Third Malignancy
64	1957	Rectum—abdomino-perineal resection (First Case)

Conclusions

1. Patients who have had one malignant tumor should be followed carefully and watched for the development of second tumors.
2. Should a tumor develop in a distant part of the body, it may well be a second primary tumor with a good prognosis, rather than a metastasis with a hopeless prognosis.
3. Second primary tumors apparently have no worse prognosis than first primary tumors.

Approved by Professional Education Committee, Georgia Division, ACS.



SURGERY OF CAROTID ARTERY OBSTRUCTION

Thomas R. Freeman, M.D. and William H. Lippitt, M.D., *Savannah*

DIAGNOSIS OF CAROTID ARTERY syndrome in stroke victims has become of great importance due to the rapid advancement in vascular surgery during the past few years. While a complete or incomplete block of the carotid artery system in the neck has been identified with some strokes for many years, it has received little attention until recently. The literature in recent months contains many reports of series of cases being successfully treated surgically. A review of large numbers of strokes reveals only about 10 per cent due to hemorrhage while the vast majority of cases are due to thrombosis in the cerebral vessels or one of the four major vessels leading to the brain. Of this latter group, an estimated 20 to 50 per cent are due to a complete or incomplete block of the internal carotid artery at or near the bifurcation. This area is accessible surgically.

While many clinical features of the disease suggest that the obstruction may be in the carotid artery, arteriography is the only means of definitely establishing the location of the block in the neck or in the brain. For this reason, it is felt that all victims of stroke should be considered for carotid arteriography without delay.

The degree of severity of symptoms following a cerebral vascular accident depends on many factors and it has been found that there is no direct correlation between the degree of block and the severity of symptoms. This is primarily due to the variance in collateral circulation. Some patients with a com-

plete block have shown only hemiparesis while others with incomplete block have shown hemiplegia. As a general rule, patients suffering stroke due to carotid artery insufficiency have episodes of transient weakness in the upper and lower extremity and aphasia when the dominant hemisphere is involved. There may be one or many such episodes prior to development of the severe stroke. Arteriography in these cases usually reveals incomplete block of the internal carotid artery reducing the flow of blood by 50 per cent or more. Frequently, patients with an acute explosive stroke, when subjected to arteriography, will be found to have a complete block of the internal carotid. If these cases are operated upon within a few hours after the onset of the symptoms, the plaque and the distal clot in the internal carotid can be removed surgically with adequate recovery, sometimes complete. It is important that these patients be subjected to arteriography as soon as possible after the onset of symptoms. One such case operated upon by us four hours after the onset of the stroke was entirely normal eight hours post-operatively.

More recently, several cases have been noted to be completely or incompletely occluded by a kink developing in the internal carotid between the bifurcation and its entrance into the skull. The position of the head in patients with tortuous internal carotids seems to be the cause of this kink. While the patient may be ambulatory when the symptoms

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

begin, it is more likely to occur when the patient is asleep and has the head turned in an extreme position to the right or the left.

These cases are handled surgically by resection of segments of internal or common carotid artery. In our series of 83 operations on 69 patients (14 bilateral), there have been ten cases of kinking, five of which were associated with plaque formation. There have been nine cases of acute explosive stroke due to complete occlusion of the internal carotid and the remaining 64 have had transient symptoms with incomplete blocks in most. Surgery in these patients has resulted in relief of symptoms in 90 per cent. Bilateral arteriography was performed in 137 patients who had suffered stroke. Hypaque solution, 50 per cent, was used in all cases without reaction. In this group, approximately 50 per cent of the patients were noted to have surgically correctable lesions. We preferred to perform these operations under general anesthesia, although in some, local anesthesia

was used. The latter carries the advantage of allowing the surgeon to talk with the patient during the time that the artery is obstructed.

In the first 20 cases, the blood supply carried by the exposed carotid was clamped off throughout the time required to remove the plaque through the arteriotomy. However, in the last 63 cases an internal by-pass of small polyethylene tubing has been used so that the blood supply to the brain is adequate throughout the operative procedure. About 50 seconds is required to place the by-pass and about 15 seconds to remove it. With this by-pass in place, the operator has sufficient time to perform more definitive surgery, particularly in the complicated cases. Post-operative arteriography is performed on the operating table before the wound is closed.

While carotid artery surgery is an important adjunct in the handling of the stroke problem, it leaves a large number of stroke victims whose lesions are not amenable to direct attack. The surgical treatment of strokes probably will always be limited and the lysins may replace all other methods of treatment in the future.

CLAUDE EDWARD TESSIER, M.D., JANUARY 30, 1905 — SEPTEMBER 11, 1959

DR. CLAUDE EDWARD TESSIER, beloved Augusta Pediatrician, died at the University Hospital after an acute illness, at the age of 54 on September 11, 1959.

Claude Tessier was born in Augusta, Georgia on January 30, 1905, the son of Louis Pommintaire Tessier and Cora Harter Tessier. His father was a physician, graduating from the Medical College of Georgia in 1896. His grandfather, Madison Monroe Tessier, was also a physician and a Medical College of Georgia graduate of the class of 1858.

As a boy Claude attended public schools in Augusta, graduating from high school in 1925; attending the University of Georgia in Athens, from 1925 to 1928; and graduating from the Medical College of Georgia in 1932. Additional studies were undertaken at Columbia University in New York and at the University of Michigan. Following an internship at the University Hospital in Augusta, he served for a year as resident at the Wilhenford Hospital in Augusta and then returned to the University Hospital for a residency in pediatrics, completed in 1935. He has subsequently served his alma mater as an assistant in clinical pediatrics, bacteriology, and public health during the period of 1943-48.

Dr. Tessier married Miss Carolyn Hickey of Columbus, Ohio on September 21, 1935. They have two daughters, Carole Ann, age 22, and Celeste, age 12. He was a member of St. John's Methodist Church.

A practicing physician in Augusta for more than 21 years, Dr. Tessier was a member of the Georgia Pediatrics Society, Southern Medical Association, the Richmond County Medical Society, and the Medical Association of Georgia. He was an active member of the

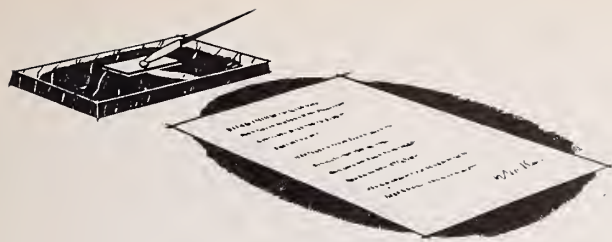
staffs at the University Hospital and St. Joseph's Hospital in Augusta.

Initiated into Alpha Gamma Chapter of Alpha Kappa Kappa in 1928, Dr. Tessier has served his chapter and his fraternity long and well. He served as chaplain in 1930, as vice-president in 1931, and as president in 1932. He was also the official delegate from Alpha Gamma to the 26th International Convention held in New Orleans in 1932. He has served as chapter primarius (1940-1957) and as district deputy (1953-1957). Consequently he brought to the Council a wealth of experience in fraternal affairs. Alpha Kappa Kappa was fortunate in having for the first time in more than 43 years a representative on the Council from one of our southeastern chapters. He was the first Grand Officer from the old South since 1914, having been elected Grand Vice-President in 1957.

Claude's quiet, unaffected manner has always won the friendship of young people with whom he came in contact. He has always been keenly interested in and an indefatigable worker for the welfare of the medical students. Popular with both young and old he has always been willing to serve in any capacity in which he was asked. Always courteous and unassuming and with never an ill word spoken of any of his associates and friends he will be sadly missed in this community.

It is with extreme regret that we mark the passing of Dr. Claude Tessier, and he shall be long remembered as the epitome of kindness and loyalty as a man of the medical profession.

—Eugene Matthews, M.D., Augusta



abstracts by georgia authors

Amerson, J. Richard, M.D. and Lumpkin, Murray B., M.D., Emory Hospital, Atlanta 22, Georgia, "Leiomyosarcoma of the Duodenum: A Source of Massive Intestinal Hemorrhage; Report of Two Cases," Am. Surgeon 25:663-669 (Sept) 59.

A review of the literature has revealed 39 previously reported cases of leiomyosarcoma of the duodenum. The authors have reported two additional cases giving their pertinent clinical and pathological findings. Gastrointestinal bleeding from these lesions responds poorly to conservative measures. The tumors usually grow slowly and can be treated surgically, often with only simple excision of the lesion. The symptomatology in the group reviewed varied from a period of several months to 13 years. The major impediment to adequate therapy appears to be failure to recognize the lesion. This is based primarily on the lack of initial symptoms, difficulty in demonstrating an extra-luminal tumor by X-ray studies, and the mimicking of peptic ulcer symptoms.

The symptoms of both presented were suggestive of peptic ulcer disease. A fatality was encountered in one from massive bleeding. The second patient had a palliative resection of the duodenal tumor and has done well post operatively.

When massive hemorrhage is an intraluminal mass of the duodenum, leiomyosarcoma should be considered. Early surgical resection is the treatment of choice.

McGarity, William C., M.D., Emory Hospital, Atlanta 22, Georgia, "Mesenteric Cysts," Am. Surgeon 25:687-691 (Sept) 59.

The four types of mesenteric cysts: lymphatic or chylous, enteric, urogenital, and dermoid and teratoid are discussed briefly in regard to classification, clinical findings and treatment. Major emphasis is given to the lymphatic or chylous cyst. Since these cysts produce no pathognomonic signs or symptoms, they are usually discovered during exploratory laparotomy performed because of complications arising from them or for unrelated conditions.

Mesenteric cysts may fall into five groups: (1) those that are discovered

during operation for some other condition or are found at autopsy; (2) those that present as a painless enlargement of the abdomen; (3) those that cause pressure symptoms manifested by vague abdominal pain and occasional nausea and vomiting; (4) those that cause intestinal obstruction due to angulation of the gut, adhesions or volvulus; and (5) those that produce symptoms of an acute abdomen following rupture and possible hemorrhage, or secondary infection.

The treatment of mesenteric cysts is surgical.

In the case reported here, a lymphatic cyst caused volvulus of the small bowel with resulting gangrene, necessitating resection of approximately 60 per cent of the small bowel as well as the cyst.

Letton, A. H., M.D. and Wilson, John Page, M.D., 478 Peachtree Street, N.E., Atlanta, Georgia, "Application of the Roux en Y Anastomosis to Diseases of the Pancreas," J. Internat. Coll. Surgeons 32:123-129 (Aug) 59.

En-Y anastomosis, which was abandoned some years ago in connection with gastrojejunostomy, has apparently found its place in the management of some pancreatic diseases. When chronic relapsing pancreatitis is due to bile being regurgitated into the pancreas, the bile may be detoured by using the Roux-en-Y anastomosis to the common duct; or when the pancreatitis is due to a narrowing of the pancreatic duct as demonstrated by operative pancreatograms, the drainage of the pancreatic fluid by amputating the tail of the pancreas and doing a caudal drainage with Roux-en-Y anastomosis has proven very useful. When a pancreatic fistula persists, it can be transplanted into the En-Y loop of jejunum with satisfactory results; likewise, when the pseudocysts of the pancreas are to be drained, the En-Y anastomosis to a defunctionalized loop of jejunum is quite satisfactory, and it is not followed by the usual operative complication. In patients with traumatic severance of the pancreas, instead of draining the area with a resultant fistula or the excision of the distal fragment, this distal fragment may be anastomosed to a jejunum En-Y (anastomosis) and the proximal end

closed. We have successfully operated two individuals in this manner, and have been very pleased with their short convalescence.

Amerson, J. Richard, M.D. and Blair, H. Duane, M.D., Emory Hospital, Atlanta 22, Georgia, "Traumatic Liver Injuries," Am. Surgeon 25:648-653 (Sept) 59.

Traumatic liver injuries still constitute a major surgical problem. Morbidity and mortality in this group is related to the degree of liver damage as well as total blood loss, the number of associated organs injured, and specifically associated injuries to the pancreas, duodenum, and colon. The mortality rate in liver injuries resulting from blunt abdominal trauma is still high. Present methods of surgical treatment of liver injuries are adequate. Drainage from the site of injury is still of prime importance.

The authors have reviewed 189 patients with liver injuries admitted to Grady Memorial Hospital in Atlanta, Georgia, during a ten year period. An overall mortality of 16.4 per cent was encountered. The relationship of the morbidity and mortality to the degree of liver injury, the blood loss resulting from the injury, and the number of associated organs injured are discussed.

Fincher, Edgar F., M.D. and Jolley, Fleming L., M.D., Emory Hospital, Atlanta 22, Georgia, "Cranial Vascular Lesions in Neurologic Surgery," Am. Surgeon 25:630-638 (Sept) 59.

This is a group of neurosurgical problems which have been treated by the author over a long period of the authors' experiences.

These lesions begin with the arteriovenous malformations of the scalp and cover a total of some 14 cerebrovascular lesions, in which neurosurgical efforts have been effective.

Aside from the scalp lesions, the blood vessel tumors of the skull, the arteriovenous malformations of the dural vessels, the traumatic implications of the dural venous sinuses, chronic subdural hematomas, cavernous sinus fistulae, intracranial aneurysms, intrinsic cerebral hematomas, as well as the cervical vertebral vascular developments are each illustra-

ABSTRACTS / Continued

ted. With each illustration, a brief discussion of each problem is presented.

There is a brief discussion of the so-called "Vascular Lesion Suspects," which can clinically simulate a cerebrovascular neurosurgical problem but which, in the final diagnosis, were proven brain tumor lesions.

The article ends with some philosophical comments regarding the surgical problems of the cerebral arterial insufficiencies resulting from vascular obliterative disease.

Fair, John R., Medical College of Georgia, Augusta, Georgia, "Congenital Toxoplasmosis," Am. J. Ophthal. 48:165-171 (Aug) 59.

1. A survey of 467 students in state schools for the blind revealed 26 cases of chorioretinitis. Of these, 22 or 84 per cent gave positive skin tests for toxoplasmosis compared with 17 per cent positive in the remaining 441 students. Twenty mothers were available for serologic study. Fifteen students with positive skin and dye tests had mothers with positive dye tests, suggesting congenital toxoplasmosis as the cause for the chorioretinitis in these cases. Three children with chorioretinitis gave negative skin and dye tests as did their mothers, indicating that some infectious agent other than Toxoplasma in the mother of a child with a positive skin and dye test for toxoplasmosis. The significance of this finding is discussed.

2. It is suggested that congenital toxoplasmosis is a public health problem worthy of real concern. Further studies are proposed with the idea of establishing the incidence of the disease.

Perdue, Garland R., M.D. and Martin, Jr., J. D., M. D., Emory Hospital, Atlanta 22, Georgia, "Parathyroid Cysts," Am. Surgeon 25:698-701 (Sept) 59.

Parathyroid cysts are rare lesions which may be sufficiently large to result in pressure symptoms or diagnostic concern because of the mass. The diagnosis at operation may be suspected by the gross appearance of a translucent cyst, usually located near the inferior pole of the thyroid. The cyst is filled with watery or opalescent fluid.

Microscopically it is characterized by a thin wall composed of parallel collagenous bundles, with nests of parathyroid cells identifiable in the wall. It is frequently lined by cuboidal epithelium, although an identifiable lining layer is often absent.

Such cysts probably arise from parathyroid parenchyma either by retention or cystic degeneration. Occasionally a cyst arising from vestigial remnants of the branchial clefts may incorporate parathyroid tissue in the wall. The cysts apparently have no functional significance.

The literature is summarized and a representative case history is reported bringing the total number of recorded cases to 26.

Fair, John R., Medical College of Georgia, Augusta, Georgia, "Stimulation of Dye-Test Antibodies in Human Volunteers Using Heat-Killed Toxoplasma," Am. J. Ophthal. Part II (Sept) 59.

Vaccination of human volunteers with whole heat-killed Toxoplasma resulted in the production of significant levels of dye test antibodies. The possibility of preventing congenital toxoplasmosis by immunizing previously uninfected (nonimmune) pregnant women is discussed. Related subjects for future study are listed.

Calk, Guy L., M.D. and Cofer, Olin S., M.D., 735 Piedmont Avenue, N.E., Atlanta, Georgia, "Pregnancy in the Latter Years of Reproductive Life," South M. J. 52:1078-1085 (Sept) 59.

The authors briefly reviewed the literature concerning pregnancy in the waning years of reproductive life. A statistical analysis of 232 cases of pregnancy in women 40 years of age or over in the past five years at the Georgia Baptist Hospital is presented. Complications of pregnancy considered more closely related to aging such as chronic vascular disease, obesity, diabetes, and fibromyoma uteri are discussed and compared to the overall hospital incidence. Complications peculiar to pregnancy along with an analysis of the outcome of all the pregnancies reaching the stage of viability were investigated and results presented. This study helps to confirm the prevalent opinion of increased risks to both mother and baby in pregnancies of women aged 40 years or more.

Martin, J. D., Jr., M.D.; Dominy, Dale E., M.D.; and Genest, A. Stephen, M.D., Emory Hospital, Emory University, Georgia, "Recurrent Carcinoma of the Colon," Am. Surgeon 25:702-706 (Sept) 59.

Residual symptoms of obstruction or continued bleeding following resection of the large bowel must be viewed with great suspicion of recurrent disease. Normally, during the healing phase following anastomosis of the bowel, radiographic evidences of obstruction may exist. This can be difficult for early distinction from active malignant disease. Necrosis and erosion of the granulomatous change may result in active intestinal hemorrhage and a suspicion of recurrence. Prolonged bleeding should be of great concern since it may occur due to overlooked disease, such as polyps or other malignant lesions, as well as recurrent disease or an inflammatory process. Preventive measures should lessen the possibility of recurrence by careful removal of all disease through an extensive resection, by application of ligatures proximal and distal to the tumor before resection, and by the possible use of anticarcinogenic agents. Even with the utilization of all prophylactic measures, some local recurrences can be expected. If there is a question of recurrent disease, re-exploration is suggested in order to remove remaining disease and to correct any existing obstruction. The likelihood of curing the disease in this late stage by further resection is questionable.

Cases are presented demonstrating problems which can be expected following treatment of these conditions.

Powell, R. Waldo, M.D. and Rooney, Donald R., M.D., Emory Hospital, Atlanta 22, Georgia, "A Study of Fatal Breast Cancer," Am. Surgeon 25:692-697 (Sept) 59.

A group of 239 patients dying with breast cancer of varying stages was studied. This represents our total experience with fatal breast cancer treated initially at our clinic from 1937 to 1957. It should be reiterated that this study differs from most others, since only patients dying with breast cancer have been studied, and no living patients have been included. From this relatively small group of patients with operable or inoperable fatal breast cancer, three findings are of special interest:

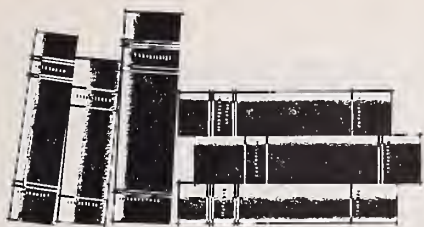
1. Longevity in this select group, computed from initial symptom or from original therapy to death is not greatly altered by any present treatment.

2. Once breast cancer becomes clinically manifest as a recurrence or metastasis, longevity computed from date of recurrence to death is not greatly affected by the original stage of the disease or by the "disease free" interval.

3. In 99 of the operable patients their initial recurrences were first clinically detected as distant metastases. It is in this group that we expect to increase longevity when methods become available to prevent or to treat blood borne metastases.

Durham, William F., Ph.D., Wenatchee, Wash.; Hayes, Wayland J., Jr., M.D., Ph.D.; and Mattson, Arnold M., Ph.D., C.D.C., Public Health Service, Savannah, Georgia, "Toxicological Studies of O, O-Dimethyl-2, 2-Dichlorovinyl Phosphate (DDVP) in Tobacco Warehouses," Arch. Ind. Health 20:202-210 (Sept) 59.

Tests have been carried out in tobacco warehouses to determine the toxicity of DDVP (O, O-dimethyl-2, 2-dichlorovinyl phosphate to mammals and its effectiveness against the cigarette beetle. In some tests, DDVP was dissolved in perchlorethylene and sprinkled on the floors; in other tests it was applied as a thermal aerosol. Dosage levels studied were 0.5, 1, 2, and 10 mg. per cubic foot. Human volunteers spent up to eight hours per day and rats and monkeys were confined continuously in the treated warehouses. Concomitant studies of the concentration of DDVP in the air were made. No signs or symptoms of DDVP intoxication were noted in volunteers or experimental animals. All species showed some degree of cholinesterase depletion after exposure to the highest DDVP application. Aerosol application of DDVP produced less cholinesterase effect than did sprinkling of a perchlorethylene solution of DDVP. It is concluded that DDVP would be safe for warehouse workers when applied twice a week or less often at a rate of 2 mg. or less per cubic foot as a thermal aerosol.



physician's bookshelf

BOOKS RECEIVED

Jakovovits, Immanuel, Rabbi Dr., **JEWISH MEDICAL ETHICS**, Philosophical Library, New York, N. Y., 1959, 381 pp., \$6.00.

Wolstenholme, G. E. W., O.B.E., M.A., M.B., M.R.C.P., and O'Connor, Maeve, B. A., **CIBA FOUNDATION STUDY GROUP NO. 1—PAIN AND ITCH**, Little, Brown, and Company, Boston, Mass., 1959, 120 pp.

Wolstenholme, G. E. W., O.B.E., M.A., M.B., M.R.C.P. and O'Connor, Cecilia M., B.Sc., **CIBA FOUNDATION STUDY GROUP NO. 2—STERIC COURSE OF MICROBIOLOGICAL REACTIONS**, Little, Brown, and Company, 1959, 115 pp.

Levine, Samuel A., M.D., ScD. (Hon.), F.A.C.P. and Harvey, W. Proctor, M.D., **CLINICAL AUSCULTATION OF THE HEART**, W. B. Saunders Company, Philadelphia, Pa., 1959, 657 pp.

Leigh, Ted F., M.D. and Weens, H. Stephen, M.D., **THE MEDIASTINUM**, Charles C. Thomas, Publisher, Springfield, Ill., 1959, 246 pp., \$11.50.

Crossen, Robert James, M.D.; Beacham, Daniel Winston, M.D.; and Beacham, Woodard Davis, M.D., **SYNOPSIS OF GYNECOLOGY**, The C. V. Mosby Company, St. Louis, Mo., 1959, 340 pp., \$6.50.

Stevenson, George, M.D. and Milt, Harry, **MASTER YOUR TENSIONS AND ENJOY LIVING AGAIN**, Prentice-Hall, Inc., Englewood, N. J., 1959, 241 pp., \$4.95.

Netter, Frank H., M.D., **THE CIBA COLLECTION OF MEDICAL ILLUSTRATIONS, VOLUME 3, DIGESTIVE SYSTEM, PART 1, UPPER DIGESTIVE TRACT**, Ciba Pharmaceutical Products, Inc., Summit, N. J., 1959, 206 pp., \$12.50.

Mozes, Eugene B., M.D., **LIVING BEYOND YOUR HEART ATTACK**, Prentice-Hall, Inc., Englewood, N. J., 1959, 212 pp., \$3.50.

REVIEWS

Croxton, Frederick E., **ELEMENTARY STATISTICS WITH APPLICATIONS IN MEDICINE AND THE BIOLOGICAL SCIENCES**, Dover Publications, Inc., New York, N. Y., 1953, 376 pp., \$1.95.

THE AVERAGE MEDICAL PRACTITIONER is lacking in a sound background of mathematics and tends to be suspicious of statistical evaluation of data. Probably because of this factor it is not uncommon for statistical methods of appraisal to be misused or misinterpreted in the medical literature. It is also common to read of poorly designed experiments to which the application of statistical tests is so much nonsense.

This new book by Croxton is concerned mainly with the mathematics of statistical tests. He hints in the

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

introduction that unless an experiment is carefully designed, statistical tests are valueless but the rest of the text, in the main, fails to mention consideration of the source of data. This feature is its main drawback for medical research workers. For example the author fails to mention the use of random number tables or the "double blind test," two commonly used procedures in medical statistics.

In the exposition of the mathematical basis of statistical tests the use of involved symbolism and the consideration for the finer mathematical subtleties would deter a reader without the necessary mathematical background.

This book might be appropriate for students of mathematics but not for medical workers.

Geoffrey E. King, M.B., B.S. (London)

Levinson, Leonard Louis, **A COOKBOOK FOR DIABETICS**, American Diabetes Association, New York, N. Y., 1959, 176 pp., \$1.00.

THIS PUBLICATION HAS BEEN scientifically planned and tested for use as a basic reference for the diabetic patient. There is a brief discussion of the well known exchange lists of sugar substitutes, vitamins, minerals, calorie counting, flavoring, etc. Low calorie, low carbohydrate recipes and menus are given in detail but are quite easily understood and appetizing.

The *Cookbook* is indexed and spirally bound for greatest convenience and will erase the necessity of collecting and filing countless diabetic recipes. This book will serve a very definite need not only to diabetics, but to physicians who have the responsibility of providing appetizing menus for their diabetic patients.

Chris J. McLoughlin, M.D.

A WAY OF LIFE AND SELECTED WRITINGS OF SIR WILLIAM OSLER, Dover Publications, Inc., New York, N. Y. \$1.50.

For those interested in Osler, here is a further collection of his addresses and essays. Whether or not Sir William Osler deserves immortality is still an unsettled question in the minds of some. This collection of his papers does not give an answer nor does it reveal anything new about his personality. For those interested in the history of medicine, his sketch on Robert Burton and his "Anatomy of Melancholy" is of interest. Osler as an essayist and historian is verbose and often more Osler than real information or idea. For these reasons this collection is less provocative than other things he has written. This little book, however, is in paper back, inexpensive and any one so inclined will not regret acquiring a copy.

Charles L. Whisnaut, M.D.

HISTORIC MEETING OF STATE BOARD OF HEALTH



THE FOURTH DIRECTOR of the Georgia Department of Public Health in 57 years was appointed September 10 by the State Board of Health, when Dr. John Venable was named to succeed Dr. Thomas F. Sellers who will remain with the Department as director-emeritus. The above photograph shows Dr. Venable and Dr. Sellers, (4th and 5th from the left standing) meeting with the Board just after announcement of Dr. Venable's appointment. In photographs on the wall are the Department's first two directors. At left is Dr. H. F. (Roy) Harris, 1903-17, and at right is Dr. Thomas F. Abercrombie, 1917-47. Dr. Sellers has served two 6-year terms since 1947, and Dr. Venable will become director

January 1, 1960. Seated are D. N. Thompson, M.D., Elberton; A. G. Little, Jr., M.D., Valdosta; A. M. Phillips, M.D., Macon; Fred H. Simonton, M.D., chairman, Chickamauga; J. M. Hawley, D.D.S., Columbus, and Maurice F. Arnold, M.D., Hawkinsville. Standing are J. G. Williams, D.D.S., Atlanta; H. P. McDonald, M.D., Atlanta; J. M. Byne, Jr., M.D., vice-chairman, Waynesboro; John H. Venable, M.D., Atlanta; Thomas F. Sellers, M.D., Atlanta; A. G. Funderburk, M.D., Moultrie; Virgil B. Williams, M.D., Griffin; Ben K. Looper, M.D., Canton; and W. W. Webb, Ph.G., Leslie. Not in photo is J. D. Butts, Ph.G., who has been seriously ill recently.

Employment for Senior Citizens

"THERE IS NO DOUBT in my mind that thousands of older persons can be helped financially through employment. And by working many thousands will be able to live happily in their later years. I am sure you will agree that arbitrary retirement, prejudice, fear, and

confusion about such terms as "old age," "senility," "deterioration," and "fitness" have caused thousands of older workers to be dismissed prematurely from a productive life."

—David B. Allman, M.D., Past President,
American Medical Association

current clinical concepts

Diagnosis of Pulmonary Carcinoma by Selective Bronchial Scrubbing Method

THE BRUSH CAN be introduced into the desired segmental bronchus under control of a right angle telescope inserted through a bronchoscope. Smear tests were performed by this method on 29 patients with lung carcinoma and the test of 27 were positive (93.1 per cent). On the same group of patients carcinoma was found on bronchoscopy in only nine (31 per cent); on examination of the sputum of bronchial secretions by the usual method in 14 (40.3 per cent) cases. No special technique in addition to routine bronchoscopy is necessary. Accuracy of diagnosis is high in comparison with that afforded by other methods.

Morito Doteuchi, Japanese Journal of Thoracic Surgery, 10: 836-849, 1957.

Fetal EKG Foretells Twin Pregnancy

TO MINIMIZE UNNECESSARY and possibly dangerous irradiation of the fetus in utero, Dr. S. D. Larks, University of California, Los Angeles, urges the use of fetal EKG, which is very clear by 20 weeks, to identify all cases of multiple pregnancy. The fetal EKG, which has complexes between 10 and 30 microvolts in amplitude, can easily be distinguished from the maternal R wave. The slightly different heart rates of twins facilitate identification.

Evaluation of Radiation Therapy of Bladder Carcinoma

SUPER VOLTAGE IRRADIATION for carcinoma of the bladder has a definite place in the management of this difficult form of urinary tract cancer.

Crigler, Fletcher, Miller, and Jones, South. Med. Jour., Vol. 52: No. 9, Sept. 1959.

Potential Productivity of the Sea

UNDER IDEAL CONDITIONS for photosynthesis and growth, the maximum potential rate of production of organic matter in the sea is probably twice as great as agricultural yields on land. This observa-

tion high lights the fallacy inherent in the philosophy of Malthus.

John H. Ryther, Science, Vol. 130: No. 3376, Sept. 11, 1959.

Danger to Children of Infection from Exposure to Urine Containing Tubercle Bacilli

POSITIVE TUBERCULIN REACTIONS are obtained twice as often in children exposed to parents with genitourinary tuberculosis as compared with the accepted figure in the general population.

Gil Vasquez, M.D., and John K. Lattimer, M.D., J.A.M.A., Sept. 5, 1959, Vol. 171, No. 1.

Appendiceal-Vesical Fistula

WHILE RARE, ACUTE pelvic appendicitis which produces the appendiceal-vesical fistula should be kept in mind when a patient is found to have pneumaturia, rectal frequency and urgency and tenderness in the pelvis on digital rectal examination.

Samuel Hyman, M.D. and Nicholas J. Capos, M.D., J.A.M.A., Vol. 170: No. 18, Aug. 29, 1959.

Carcinoma of the Esophagogastric Junction

IF THE CARCINOMA is confined to the esophagus the prognosis is better either with the adenocarcinoma variety or the squamous cell variety. Once a carcinoma has extended into the region of the cardiac aspect of the stomach the prognosis is not nearly so good. Symptoms may be only two weeks or maybe from six to eight months in duration.

THE BEST PALLIATION in the treatment of carcinoma of the esophagus is resection in order to prevent the dysphagia and bleeding which always ensues in these cases. If this cannot be done the patient should be carefully dilated and given x-ray therapy.

IT IS WISER to do a left upper muscle retracting abdominal incision and examine the region of the coeliac axis and the stomach in this area to determine operability. If this area is uninvolved then an incision can be made into either chest to expose the lesion and to do the resection. If the carcinoma involves the area of the coeliac axis in an intimate fashion then the patient is obviously inoperable. If the nodes are positive on resection then the patient should be given x-ray therapy.

It may often be necessary to do an esophagogastricostomy to bypass the lesion if it is completely inoperable.

THE CARCINOMA MAY be slow to manifest itself where the lesion is confined to the esophagus. The dysphagia it causes may be mild and even inconstant but early examination and detection are essential to obtain best results from surgery.

From a talk "CARCINOMA OF THE ESOPHAGOGASTRIC JUNCTION" given by Dr. Valter Brindley, Jr., Associate Professor Clinical Surgery, University of Texas, at the American College of Surgeons' meeting, Sea Island, Georgia, September, 1959.



the association

ANNOUNCEMENTS

The twenty-third annual meeting of the New Orleans Graduate Medical Assembly will be held March 7-10, 1960 at the Roosevelt Hotel.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners.

Following the meeting in New Orleans, arrangements have been made for a clinical cruise on the M/S Franca "C" to the West Indies, leaving from Port Everglades, Florida on Saturday, March 12. The itinerary includes visits to Puerto Rico, Virgin Islands, Martinique, Barbados, Trinidad, Curacao, and Haiti, returning to Florida on Friday, March 25.

Details on the New Orleans meeting and the cruise are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

Surgeons and related medical personnel are invited to attend the three-day Sectional Meeting of the American College of Surgeons in Louisville, Kentucky, January 21-23, 1960. Headquarters will be The Brown Hotel.

The Department of Ophthalmology of the Emory University School of Medicine announces a postgraduate course in Applied Ophthalmic Pathology on December 3-4, 1959 at the Grady Memorial Hospital, Atlanta, Georgia. The guest lecturers will be Dr. Lorenz Zimmerman of the Armed Forces Institute of Pathology, Washington, D. C., Dr. T. E. Sanders of Washington University, St. Louis, Mo., Dr. J. A. C. Wadsworth of Columbia Presbyterian Medical Center, New York, N. Y., and Dr. J. T. Godwin of Atlanta, Ga.

Mycobacterial and Mycotic Diseases with Special Reference to Childhood will be discussed by a number of medical authorities at a one-and-a-half days conference in New Orleans, La., December 10-11, 1959.

DEATHS

JOHN MARCUS KENYON, 89, of Richland died at his home September 17.

Dr. Kenyon received his medical education at Vanderbilt University and later attended Tulane and

other universities. He practiced in Preston and Weston for 14 years before moving to Richland in 1908.

He was a member of the Medical Association of Georgia, American Medical Association, The Third District Medical Society, and the Randolph-Terrell Medical Society. He was also a member of the Richland Baptist Church.

Dr. Kenyon was awarded a past due 50-year pin from the Medical Association of Georgia at a meeting in Savannah in 1949.

Survivors include a daughter, Mrs. Evelyn Sands, Groveland, Fla.; four brothers, Hollis Kenyon, Parrott, Olin Kenyon, Macon, and Allen and Raphael Kenyon, both of Morrow; four grandchildren; and five great-grandchildren.

JOEL LEE PORTER of Ruthledge died September 18 in a private hospital following a lingering illness.

He was a member of the Newborn Methodist Church and had been a member of the Medical Association of Georgia for over 50 years.

Survivors include his wife; one brother, W. R. Porter of Newborn; and a number of nieces and nephews.

CLAUDE EDWARD TESSIER, 54, of Augusta died September 11 at a local hospital.

Dr. Tessier was a member of the Richmond County Medical Society, Elks Lodge No. 205, and was Grand Vice President of Alpha Kappa Kappa.

Survivors include his wife; two daughters, Carole Ann Tessier and Celeste Tessier; his mother, Mrs. L. P. Tessier; two sisters, Mrs. C. B. Johnson of Allendale, S. C., and Mrs. W. Lee Flowers of Lake City, S. C.; a niece and a nephew.

BERT TILLERY of Columbus died September 22 at the age of 70.

Dr. Tillery attended Wynnton Academy for Boys before entering Tulane Medical College.

He is especially remembered for his work in the establishment of St. Francis Hospital in Columbus.

Survivors include a daughter, Mrs. Robert Ober, Baltimore, Md.; two grandchildren; three brothers, Clay Tillery, Opelika and Lee and Floyd Tillery of West Point; a niece and a nephew.

PERSONALS

First District

ELLISON R. COOK, JR., JULES VICTOR, T. A. McGOLDRICK, JOHN L. ELLIOTT, and FENWICK NICHOLS appeared on the forum given at the premiere of "Second Chance," a documentary stroke film, shown in Savannah.

Second District

TOM EDMONDSON of Tifton gave a demonstration of hypnotism for the Tifton Kiwanis Club recently.

Receiving praise from the GHA Committee of Cardiovascular Clinics for their "unselfish support" of the Thomasville Clinic during the past year were GEORGE R. DILLINGER, ERNEST F. WAHL, and OSCAR MIMS.

WILLIAM L. BRIDGES, JR., of Tifton, has recently been certified as a member of the American Board of Pediatrics.

Third District

The following officers were elected by members of the Sumter County Cancer Society; president, W. R. ANDERSON of Americus; board chairman, J. H. ROBINSON, III; vice president, medical doctors, R. A. COLLINS; and professional education chairman, R. C. PENDERGRASS.

A. J. KRAVTIN of Columbus recently spoke to the members of the Medical Auxiliary to the Muscogee County Medical Society.

CLARENCE C. BUTLER of Columbus has been named one of the vice presidents of the Georgia Heart Association for 1959-1960.

WOODROW GOSS of Ashburn recently attended the International College of Surgeons in Chicago.

Fourth District

ROBERT M. WEST has announced the opening of his office in Jonesboro for the practice of general medicine.

At a recent meeting of the Barnesville Rotary Club, GEORGE L. WALKER of Griffin was guest speaker.

Fifth District

J. WILLIS HURST of Atlanta has been named secretary of the Georgia Heart Association for 1959-1960.

The immediate past president of the Georgia Heart Association, J. GORDON BARROW of Atlanta, was one of the members of a forum held in connection with the premiere showing of "Second Chance," a documentary stroke film, in Savannah recently.

JOSEPH A. HERTELL, chief medical resident at Piedmont Hospital, has been invited by the University of Lima Peru Medical School, to set up equipment for analyzing plasma proteins in disease at the school. This equipment has been in use at Piedmont Hospital for the past year and has proved a valuable diagnostic tool. Dr. Hertell will also give lectures at the Medical School during his stay in Lima on plasma proteins.

At a recent meeting of the American Roentgenology Society in Cincinnati, TED F. LEIGH of Atlanta was elected Chairman of the Scientific Exhibits Committee.

DR. and MRS. MURDOCK EQUEN of Atlanta

attended the meeting of the American College of Surgeons in Atlantic City recently.

A. H. LETTON of Atlanta spoke to the Seventh District Medical Society in Lookout Mt., Tenn. on "Carcinoma of the Thyroid". He also addressed the Atlanta Baptist Pastors Conference held in Atlanta and the Atlanta Civitans recently.

JOHN F. VENABLE who has been acting as director of the Milledgeville State Hospital was elected director of the State Health Department by the State Board of Health succeeding T. F. SELLERS, veteran director of the department and a member of it since 1918.

The first of a four-month series of forums on public health sponsored by the Fulton County Medical Society was moderated by J. N. BRAUNER, JR. of Atlanta.

Recently JOHN F. VENABLE of Atlanta spoke to the Atlanta Chapter of the Southern Industrial Editors Association on proposed changes and present conditions at the Milledgeville State Hospital.

Sixth District

E. Y. WALKER of Milledgeville was named chief of the medical staff of the Baldwin County Hospital at the annual meeting of the Hospital Authority and the medical staff of the hospital. CURTIS VEAL of Milledgeville was named assistant chief and ZEB BURRELL, JR. of Milledgeville was named secretary.

Seventh District

No news submitted.

Eighth District

ARTHUR M. KNIGHT, JR. of Waycross was recently chosen president-elect of the Georgia Heart Association for 1960-1961.

E. R. JENNINGS of Brunswick recently addressed the Hospital Auxiliary in Brunswick.

Ninth District

FREDERICK BLOODWORTH of Gainesville participated on a panel discussing TB clinics in Georgia at the annual meeting of the Georgia Tuberculosis Association held recently.

R. E. SHIFLET of Toccoa has announced that he will attend the University of Pennsylvania during the next several months doing graduate work in medicine.

Tenth District

At a recent meeting of the Georgia Heart Association, A. CALHOUN WITHAM of Augusta was installed as president for the coming year.

Recently VICTOR C. VAUGHAN III of Augusta presented two key speeches during the annual meeting of the Alabama Chapter of the American Academy of Pediatrics in Point Clear, Ala.

WALTON W. HAMILTON of Augusta recently opened offices in Augusta for the practice of radiology.

DR. and MRS. C. H. DICKENS of Madison have returned from a trip that took them to Daytona Beach, Fla., Jekyll Island, and Sea Island.

J. B. NEIGHBORS, JR. of Athens received a Gold Service Recognition Medal from the Georgia Heart Association at its annual meeting held in Savannah in September.

Doctors from Augusta that attended the annual convention of the American College of Surgeons in At-

lantic City were: WILLIAM H. MORETZ, HAROLD ENGLER, GEORGE W. SMITH, ROBERT RINKER, ROBERT G. ELLISON, and DAVID P. HALL.

SOCIETIES

At a recent meeting of the CARROLL-DOUGLASHARALSON MEDICAL SOCIETY, Dr. Harrison Reeves of Atlanta, spoke on "Leukemia—Differential Diagnosis and Treatment."

Dr. Leo M. Wachtel, Jacksonville, Fla., who is a member of the Commission on Hospitals for the American Academy of General Practice, was the principal speaker at the recent combined meeting of the DeKalb County Hospital Authority and the Medical Advisory Committee of the DEKALB COUNTY MEDICAL SOCIETY.

Mental health was the topic of the first of a series of free public medical forums sponsored by the FULTON COUNTY MEDICAL SOCIETY recently held at the Academy of Medicine.

J. H. Nicholson and C. H. Dickens were hosts to the OCONEE VALLEY MEDICAL SOCIETY at a meeting at Dr. Nicholson's home in Madison recently.

The SOUTH GEORGIA MEDICAL SOCIETY met

recently at the Moody Air Force Base Officer's Open Mess with Col. Harold Ellingson, director of space medicine, School of Aviation Medicine, Brooks AFB, San Antonio, Texas as guest speaker.

The STEPHENS COUNTY MEDICAL SOCIETY, in support of the local athletic program, gave medical examinations to all prospective football players. In cooperation with the local chapter of the American Cancer Society, movies on cancer detection and prevention were shown to interested persons every day of the week beginning September 7. A physician was in attendance at each showing to answer questions. The members were also hosts to the NINTH DISTRICT MEDICAL SOCIETY'S fall meeting.

A clinical discussion on malignancies of the head and neck was presented at the WARE COUNTY MEDICAL SOCIETY'S meeting recently. Dr. Curtis M. Phillips of Jacksonville was the speaker for the scientific program.

The semi-annual meeting of the SECOND DISTRICT MEDICAL SOCIETY was held recently at the REA Auditorium in Camilla.

Recently the SEVENTH DISTRICT MEDICAL SOCIETY held its meeting at the Fairyland Club in Lookout Mountain, Tenn.

The NINTH DISTRICT MEDICAL SOCIETY held its Fall meeting at the Toccoa Country Club in Toccoa recently.

The following officers were elected at a recent meeting of the TENTH DISTRICT MEDICAL SOCIETY: Marion Hubert, Athens, president; M. D. Adair, Washington, vice president; and S. K. Brown, Augusta, secretary and treasurer.

POWERFUL ATTEMPT TO ENACT FORAND BILL PREDICTED

THE U. S. CHAMBER OF COMMERCE and two key Congressmen, all opponents of the so-called Forand bill, recently issued separate warnings that an all-out effort will be made to get the controversial legislation through Congress next year.

In its weekly report to members, the Chamber predicted there will be "a powerful attempt" in the next session of Congress to enact the bill (H. R. 4700) which would increase social security taxes to help pay for the cost of the Federal government providing surgical and hospital care for social security beneficiaries.

The Chamber warned that passage of the legislation would mark "a major break-through into the welfare state." It "probably would lead to a compulsory Federal program providing complete medical care for everyone," the Chamber said.

There would be "no stopping" of such a program once it got started, the report said.

The Chamber called upon communities to find orderly solutions to the problems of the aging. Other-

wise, solutions "will surely be imposed from Washington," the report added.

Similar warnings were voiced by Reps. Richard M. Simpson (R., Pa.) and Thomas B. Curtis (R., Mo.), key members of the House Ways and Means Committee where the bill was put on the shelf last session.

Rep. Curtis urged that the medical profession and other leading opponents make a strong counter-drive in an all-out effort to block passage of the bill next session. Unless there is such action, he said he would have to "regretfully" predict that legislation along the lines of the pending bill probably will be enacted in 1960.

Rep. Simpson said that H. R. 4700, and similar legislation affecting the medical profession, "make it imperative that every doctor keep informed on legislative issues before Congress." He also urged that physicians "become patriotic political forces" by giving "their informed viewpoint" to lawmakers at all levels of government.

Rep. Simpson said it "is important" that opponents

of H. R. 4700 develop "appropriate alternatives" to solve the health care needs of the aged.

He promised to continue to cooperate with the medical profession to guard "against the disastrous consequences of compulsory national health insurance.

"House Democratic Leader John McCormack of Massachusetts expressed hope that Congress next year will stamp final approval on another bill of particular interest to physicians. He praised the Keogh-Simpson bill (H. R. 10) as "meritorious legislation" and said it "should be enacted into law next year." The measure, which was passed by the House last spring but left hanging in the Senate Finance Committee, would provide income tax deferrals for self-employed persons setting aside money for private retirement plans.

Committee on "Program and Progress" Proposed

A National Republican Committee on "Program and Progress" proposed a far-reaching health program to be carried out by the Federal government in partnership with states and local governments.

Its goals would include: enlarging the capacity of medical schools so that 3,000 more doctors could be graduated each year, providing more hospital and nursing home beds, and supplementing hospital facilities with clinics, day-care centers and more visiting nurses to care for patients in their own homes.

The progress of medical science would be furthered by continued Federal support for basic medical research. But such Federal support would be given under

conditions to encourage maximum non-Federal spending on medical research and to prevent "too great a diversion . . . of doctors required for the equally urgent needs of teaching and medical practice." It was estimated that expenditure of \$1 billion a year—equally divided between the Federal Government and non-Federal sources—would be required by 1965.

Other Recommendations

Other recommendations included: vigorous Federal support of preventive health programs, and expansion and greater flexibility of voluntary health insurance programs.

"A free people and a free medical profession can achieve these goals with the wise support of government, without bureaucratic restrictions or interference with the physician-patient relationship which has made American health services a model for the free world," the Republican Committee stated.

The Committee proposed a five-point "partnership" program: 1) short-term Federal aid for construction of medical school buildings, 2) changes in the present hospital construction program to encourage renovation and repair of outmoded hospitals, 3) Federal guarantees for mortgages to finance construction of private nursing homes on a basis assuring high standards of quality in construction and operation, 4) encouragement of construction of diagnostic and outpatient facilities in rural areas and the building of mental health clinics, and 5) Federal aid to cities "in more effective planning and coordination of health services."

IF YOU'RE REALLY SICK, DON'T GRIPE ABOUT COST OF LIVING

RECENTLY, I SPENT NEARLY two weeks in Macon Hospital. It was not a serious illness, but something was wrong with me. I went there and the nurses cared for me while a patient; the doctors worked with technicians and specialists; found out what my trouble was and proceeded to correct it.

Sure, it cost money. The hospital had to be paid. The doctors' bills have to be met. Compensation had to be made for the special checks, tests, and services. But it was my health at stake. I figure I got a bargain. If my condition hadn't been corrected, eventually it would have gone into something really serious and I never heard of anybody under a tombstone producing any income to provide for his family or to pay doctor or hospital bills.

That is why I get out of patience sometimes with people who have been brushed closely by the dark angel of death and spend the rest of their lives complaining about how their treatment dented their pocketbooks. What they are really griping about is the cost of living. Because that is exactly what they paid: an amount of money to be kept alive.

No doubt about it, adequate medical care and hospitalization is expensive—terribly expensive. There is a lot of truth in the observation that only the very

wealthy, who have loads of money, or the very poor, who get charity care, can really afford a serious illness.

But with death knocking on the door, with pain flickering like a flame through the body, only a fool or a man welcoming an end to his life argues about the cost of being kept alive. Who can put a price on life? A dangerously sick person sets no ceiling. He wants everything that can possibly be done for him done, quickly. Hang the expense.

It is only later, after he has been nursed back to good health and is able to resume his normal routine, that what had once been gratitude to a devoted doctor turns to resentment. It is then that he forgets how the expensive equipment in a great hospital helped keep him from plunging over the cliff of life and he begins telling friends and acquaintances what robbers they have up at the hospital.

Doctors are in the business of keeping people alive and in good health. When a doctor says you should go to a hospital, it is senseless to ignore expert advice you are paying for.

If you like to be alive, sometimes you may have to pay to remain so. When that time comes, no price will seem too high.

—Macon News



DAZZLING DOWNTOWN DALLAS, as heart of a metropolitan area with over 1 million population, presents one of the nation's most dramatic skylines. It includes two tallest buildings west of the Mississippi River. In

the foreground is the new Memorial Auditorium, site of the 13th clinical meeting of the American Medical Association.

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A practical program for physicians who want a first hand review of the latest approaches to patient care.

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The beautiful new Memorial Auditorium within walking distance from downtown Dallas is the site for the 13th A.M.A. Clinical Meeting. Completely air-conditioned, the Auditorium features 110,000 square feet of exhibit space, a 1,773-seat theater and 10 meeting rooms where the scientific sessions will be held. There is also a 1100-car parking lot adjacent to the building.

Dallas, population 1,050,000, is rapidly becoming one of the great convention centers of the nation. It combines old fashioned Texas hospitality with some of the most modern convention facilities to be found anywhere. It has excellent skyscraper hotels, and numerous night clubs and restaurants presenting top-flight entertainment.

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Rheumatoid Arthritis—W. Paul Holbrook, Tuscon, Ariz. Panel Moderator

Colloidal Isotopes and Leukemia—Joseph M. Hill, Dallas—Lecture

Treatment of Diabetes—Randall G. Sprague, Rochester, Minn.—Panel Moderator

Infectious Diseases in Children—Harris D. Riley, Jr., Oklahoma City—Panel Moderator

Tranquilizers in Medical Practice—Stewart Wolf, Oklahoma City—Lecture

Surgical Approaches to Parkinson's Disease—William W. McKinney, Fort Worth—Lecture

Congestive Heart Failure—James V. Warren, Galveston—Panel Moderator

Peptic Ulcer in Rheumatoid Arthritis—Lloyd G. Bartholomew, Rochester, Minn.—Lecture

Immunization and its Future—Blair E. Batson, Jackson, Miss.—Lecture

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This disease remains an active threat in spite of the recent advances in immunization.

Joseph H. Patterson, M.D., *Atlanta, presiding*

Dr. W. Lorraine Watkins: This three-and-a-half year old white male was admitted to Eggleston Hospital July 28, 1959, with a chief complaint of paralysis of the left leg. The child had apparently been well until five days prior to admission, when he developed mild fever in the evening. This responded well to one aspirin tablet, but the next evening he developed fever again and complained of not feeling well. The following morning he was vomiting; still running some fever and was taken to his local doctor who gave him one injection of penicillin, an oral liquid medication, and some nose drops. However, he remained symptomatic and two days prior to admission he developed a dragging of his left leg. The following day he was taken again to his doctor who, noticing some nuchal rigidity, referred him to the Crawford W. Long Hospital. A lumbar puncture performed on admission revealed 250 WBC, 50 per cent lymphocytes and 50 per cent polymorphonuclear cells. The spinal fluid protein was 44 mg. per cent, sugar 67 mg. per cent, chloride 130 mg. per cent. A smear was negative. The peripheral white blood count was 12,600 with 75 per cent polymorphonuclear cells. He was kept at Crawford W. Long Hospital only one day, where his course was not too

remarkable except that he had acute urinary retention requiring catheterization. He was transferred to Eggleston Hospital for isolation purposes.

His past history is of interest in that he is reported to have had three Salk vaccine injections, the most recent having been one year prior to admission and the two others six and seven months prior to this last injection.

On admission to Eggleston, his temperature was 100.8 rectally, his pulse 140, respirations 26, BP 98/70. He was a well developed, well nourished white male who was in no distress but did appear acutely ill. Examination of the head and neck revealed moderate nuchal rigidity with considerable pain on anteflexion of the neck. Examination of the ears, nose, and throat was negative. Examination of the heart and lungs was not remarkable. Examination of the genitalia revealed a mild hypospadias. The most remarkable findings were in his neuromuscular system. His cranial nerves appeared intact except on admission there was a coarse tremor of his tongue which did not progress. He had good cough and swallow reflexes and respirations were adequate. There was some weakness of grasp noted on the right. The left lower extremity apparently was completely normal, but a flaccid paralysis of the left lower extremity and general weakness of the right

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lower extremity were noted. The left Achilles and left patellar reflexes were absent. The remainder of the deep tendon reflexes were felt to be definitely suppressed, particularly in the right lower extremity. Superficial reflexes, cremasterics and abdominals were active and equal bilaterally. No pathologic reflexes were noted. There was some general hyperesthesia over the lower extremities but no gross loss of sensation. Laboratory findings on admission to Egleston were: Hbg. 13.8, WBC 9,700 with 64 per cent polymorphonuclear cells, 31 per cent leukocytes, three per cent monocytes, and two per cent metamyelocytes. Urinalysis was negative except for a moderately positive acetone. A lumbar puncture was not performed here. While in Egleston his temperature rose to 102.4° rectally his first day, but he became subsequently afebrile and was completely afebrile on his third hospital day. He had some difficulty with urinary retention; however, he did not require catheterization. He had general progression of his paralysis through the third hospital day with rather extensive involvement at the time of discharge, which was on his sixth hospital day, August 3. He possibly had some weakness of his neck muscles, certainly some spasm. It was felt that some weakness was present in both shoulder girdles, with fairly good action of his deltoids, however. Both lower extremities were essentially flail except for some activity of the flexors of the right toes and possibly some activity in the adductors of the right hip. Chest and abdominal musculature were apparently normal except for a good deal of spasm in some of the back muscles, which made evaluation of weakness difficult.

Dr. Patterson: This child was transferred to Warm Springs where the muscle deficits were delineated in greater detail, but the findings there in the convalescent period were substantially the same as described here at Egleston. Dr. Watkins, what about the serological and stool reports on this child?

Dr. Watkins: Polio I virus was recovered from the stool.

Dr. Patterson: The first speaker this morning will be Dr. Harold W. Wylie, Jr., Chief of the Poliomyelitis Surveillance Unit of the Communicable Disease Center, who will discuss the present status of poliomyelitis in the United States.

Dr. Wylie: Through August 8, 1959, a total of 2,482 cases of poliomyelitis, 1,560 of which were paralytic, were reported to NOVS. This is approximately three times as many paralytic cases as were reported during a similar period in 1958 and twice as many paralytic cases as were reported through the first week of August 1957. During the past five years,

the annual increase of poliomyelitis was lowest in 1957, and 1959 falls between 1956 and 1958, the second lowest. A comparison of paralytic poliomyelitis was made during the same five-year period. The year 1959 is more comparable to 1956 and 1955 than to 1958 or 1957, which indicates a rapid early increase in reported paralytic polio this year. This is one factor which has made 1959 such an extraordinarily interesting year.

The polio season started early, a result of increase of reporting from the Gulf States, particularly Dade County, Florida and Hidalgo County, Texas. Not only was there unusually early reporting from those areas, but in addition, it was heavier than usual. Soon thereafter the first urban epidemic began in Des Moines, Iowa. This was a surprisingly early time for a mid-western epidemic, for both the Chicago and Detroit epidemics began later, around mid-July. An interesting thing occurred in the Des Moines epidemic. During June the first 30 cases of poliomyelitis occurred and were sharply localized to one or two census tracts within the city which were predominantly lower economic areas. These cases were all Negro and mostly paralytic.

In July only one other Negro case occurred, the rest being white cases and numbering approximately 60. These were predominantly non-paralytic, quite the opposite of the Negro cases. What we saw in Des Moines was a sharply localized paralytic epidemic in Negroes followed by an increased incidence of non-paralytic poliomyelitis in the white population, which spread throughout the city in all census tracts and in all economic groups. Later in June the second urban epidemic began in Kansas City, Mo. Through August 12, 128 cases, 60 of which were paralytic, were reported. Again, there was a heavy predominance of Negro cases. There have as yet been very few white cases. This was also the situation early in the Des Moines epidemic, where the Negro epidemic was followed by an increased incidence of white cases. Will we have an upsurge in white cases following that Negro outbreak in Kansas City? In Kansas City as well as Des Moines, most of the cases were sharply localized geographically and there was a predominance of paralytic cases among unvaccinated pre-school children. Forty-three of the 67 cases were ages zero to four, 32 of which were unvaccinated. Only five of the Kansas City paralytic cases had received three or more doses of the Salk vaccine. Currently a third urban epidemic is underway in New Haven, Conn. So far there have been 45 cases. Most have developed over the past month, and our information indicates that they are predominantly among pre-school Negro children and are sharply localized to four different neighbor-

hoods. There have already been four fatalities.

There is a distinct common pattern to these urban outbreaks. First, they have been heralded by Negro outbreaks; secondly, they have been localized sharply to particular areas within the city; and thirdly, the cases have been primarily among pre-school children who have not been vaccinated.

This year, in contrast to 1958, we have received reports of many localized clusters of cases in widely distributed areas of the country. Last year most of the cases were in five different epidemic areas: Detroit, Mich.; the urban counties of New Jersey; San Antonio, Tex.; an Indian reservation in Montana; and some mining counties in Virginia and West Virginia. This year we have seen clusters and concentrations of cases virtually from coast to coast, but particularly in the mid-west. For example, there is Pulaski County where so far there have been 48 cases, 40 of which were paralytic. These cases were within the city limits of Little Rock, and in the metropolitan area, including North Little Rock and the surrounding suburbs. Again, 19 of these cases were Negro; 24 of the paralytic cases were pre-school children; and only seven had been fully vaccinated. Other examples of concentrations are Lincoln, Neb., Oklahoma City, Okla., Dallas, Houston, and Ft. Worth, Tex., Terrebonne Parish, La., Mobile, Athens, and Huntsville, Ala., and in Sedgwick County, Kan.

In our South Atlantic region concentrations have been reported in North Carolina and Virginia. In North Carolina there have been 73 cases so far this year, where there were eight cases through this date last year. It is of particular interest that of the four military installations in North Carolina, three have had epidemics of polio. In Ft. Bragg there were 10 cases, all of which were paralytic and two were fatal. In Camp Lejeune there were nine cases with three deaths. In Cherry Point Marine Air Station there are now five cases. It is difficult to explain why in Fort Bragg and Camp Lejeune more cases have not developed. In both instances the cases occurred over a period of one and a half to two weeks and then, in spite of the large populations, reporting of new cases stopped. In Virginia there was a sharp increase in polio noted last August 8, a rise from 13 to 40 cases. Most of these cases were in the panhandle region, in Buchanan County. Last year in this general area a heavy epidemic of poliomyelitis was seen. Fortunately, this year most of these new cases are non-paralytic and it is believed that perhaps they may be aseptic meningitis caused by enteroviruses other than the poliovirus.

In the surveillance report the highest proportion of the paralytic cases was among pre-school children,

largely unvaccinated. Four-hundred-ninety-three of the 1,000 or 1,100 paralytic cases were in this age group, and only about 15 per cent of the paralytic cases had received three or more vaccinations. It is interesting that 353, or about 35 per cent, of the white cases were in the pre-school age group, whereas about 61 per cent of the Negro cases were in the pre-school age group. Also, 16 per cent of the white cases which were paralytic had received three or more shots and only eight per cent of the Negro cases had received three or more shots. I think that this is indicative of two things. First, it reflects the problem we are having with the Negroes this year, especially Negro pre-school children. The over-all attack rate in the country for Negroes is twice that of whites. The second thing is the poor vaccination status of Negroes. Only half as many Negro paralytic cases were vaccinated as were whites, reflecting the poor utilization of the vaccine.

So, in summary, it has been shown that 1959 is a worse year for paralytic poliomyelitis than 1958 and 1957. We have already had three urban outbreaks and, in contrast to last year, we have had numerous cases in little clusters and concentrations throughout the entire country. Again, the toll is highest in pre-school children, as it has been since 1955—particularly among unvaccinated Negro children.

Dr. Patterson: Dr. E. Russell Alexander, Chief of the Surveillance Section of CDC, will discuss vaccine, including quadruple antigen preparations.

Dr. Alexander: The history of Salk poliomyelitis vaccine development is one with which you are all familiar, including the tragic disaster of contaminated vaccine from one source at the beginning of the widespread use of vaccine. The history beyond that point is one in which we can all share some pride. The vaccine has been shown to be effective. A schedule of vaccination was proposed from the start of the Michigan field trials and, following this, by Dr. Salk and others, and is one well known to us. This is the schedule of a primary immunization series of three injections, two of them one month apart followed by a third seven months after the second.

After initial emphasis on achievement of primary immunization in children, the question of duration of artificial immunity began to arise. In consideration of studies made of antibody response and duration of immunity to Salk vaccine, it must be remembered that vaccine potency has continued to be variable year to year, and between company products. In 1955, increased emphasis on safety standards of vaccine resulted in decreased potency. This problem has gradually diminished and the vaccine which we buy commercially today is more potent in its antibody forming abilities than the one

of a few years ago. This change has been continuous. As pediatricians, the second problem in choice of optimal vaccine schedules must be the influence of maternal transfer of passive antibody on the primary infant immunization. The half-life of polio antibody is approximately five weeks. This passive antibody will be inhibitory to artificial immunization in these early months.

A third factor affecting infant immunization is the tolerance phenomenon or the inability of the very young infant to respond to some antigens satisfactorily. A series of publications in the last few years have raised the issue of a fourth dose of Salk vaccine. These include the studies of Gordon Brown, presented in an address at the Michigan School of Public Health in January 1959, of Batson and Christie (in *Pediatrics*, March 1959). Also, Dr. Fred Robbins at the October 1958 Academy of Pediatrics meeting spoke of the studies he had been doing in relation to persistence of antibodies in infants. From these studies it was apparent that there was need to review the recommendations and this was done by a number of different bodies, including the American Academy of Pediatrics, the Conference of State and Territorial Epidemiologists, and the Polio Advisory Committee of the Public Health Service. I would like to read the recommendations of the Surgeon General as of June 28, 1959, on this subject. This recommendation was based on the advice of an advisory committee to the Public Health Service.

First, the completion of the basic series of three injections of Salk-type polio vaccine is recommended for persons under the age of 40. For persons over the age of 40 it was stated the vaccinations can also be beneficial but are less urgent because of the infrequency of poliomyelitis in this older age group. The recommended basic schedule was restated, that is, an initial injection followed by a second injection four to six weeks after the first, and a third injection seven to 12 months after the second dose. One of the basic changes, however, in this recommendation was in the recommendation of a basic schedule of four injections for infants less than six months of age. This is a series of three injections of 1 cc. of polio vaccine spaced one month apart beginning before six months of age, as early as two months of age, followed by a fourth injection at seven to 12 months after the third dose. In addition, it was stated that polio vaccine for infants and young children may be given in separate injections or as quadruple vaccine, which combines polio vaccine with diphtheria, pertussis, and tetanus vaccine. The schedule

recommended by the manufacturers of such quadruple vaccines can be followed when this product is used. The basis for this recommendation of four injections is that a primary series when begun in infants under six months of age cannot develop adequate antibody response from three injections so that a fourth primary injection appears to be desirable. Included was the statement that complete information on optimum dose schedules will require further experience with separate and quadruple vaccines. I want to come back to that point in just a minute. Then they go on to recommend a booster dose of 1 ml. of vaccine to persons under 40 years of age who have completed the basic series of three doses at least one year previously. This is the recommendation for the fourth injection. There was a recommendation for a single booster injection for individuals who were planning travel in areas where the incidence of polio was high. It was also suggested that when local epidemics of polio are beginning, an emergency booster dose may be given as early as one month following a previous dose of vaccine regardless of the number of previous doses. One booster was recommended when pre-school children are to enter school and for pregnant women prior to the polio season, both for their own protection and for the passive antibody given to the infant to be born. Finally, persons in the areas where sanitation may be poor or polio is known to be present were also recommended for a booster dose.

In summary, with particular reference to the fourth injection, this was the same recommendation that had been made by these other two bodies mentioned before, the American Academy of Pediatrics and the Conference of State Epidemiologists. The new thought in here was the recommendation on the basic schedule of four injections for infants. In addition, new in this recommendation was the inclusion of the quadruple or quadrivalent vaccine, which I am sure many of us are using at the present time. As you know full well, the trouble with this is the confusion that will exist when a new product comes out and particularly when it comes out from two drug companies who have apparently a different schedule that they think is optimal. I think the point to stress in this matter is that neither of them have had time to establish thoroughly that one schedule is better than the other but that there will be in the near future some equalization. I personally look upon this in the same way as the 33 1/3 and 45 rpm. It is confusing for you at the present time, particularly when you have patients who go from one person to another and they get mixed up between one schedule and another. This will all iron itself out in the near future. The other thing is that it is said of these quad-

ruptle vaccines by each of these companies, and this should be stressed again, that this is a material primarily aimed at infant immunization and the diphtheria antigen, as such, and probably pertussis too, should not be used on persons over the age of six. Schick tests should be done before this material is given, particularly in the 10-year-old age group where they might get reactions to the diphtheria toxoid.

Dr. Langmuir: Dr. Wylie emphasized the Negro problem, I think perhaps a little too much. I don't think it is a racial situation so much as it is a problem of economic conditions and crowding. Also, unvaccinated population groups are involved. He didn't mention a mid-winter Amish epidemic in Missouri that occurred where large unvaccinated families were crowded together under suboptimal circumstances. Neither did he mention the Indians in Montana, the Mexican labor group in San Antonio. Certainly there is a lot more polio this year than I or any of my associates deigned to predict. Some of my immediate group bet there would be somewhat more than last year. I wagered that there would be fewer than last year, but I don't think any of us had anticipated this much of an increase. I don't believe this is in any way evidence of the failure of the vaccine or of a break through from children immunized some years before. It can't be. The piling up of the cases in the very young age group means there must be fairly recently vaccinated children in this younger age group, but, even so, the selection in this group indicates they are going to the unvaccinated children rather than to the vaccinated. There is no pumping up of the cases in the 5-to 10-year age group, which would be an indication of loss of immunity from an earlier vaccination. Therefore, our problem is a sociological one of getting the group that has no private physician and that pays no attention to the normal responses—those that don't read the paper or listen to television and don't respond in the same way this is the group to get immunized. But I don't think we should call this particularly a Negro problem and I see no evidence that it is a failure of the vaccine.

Dr. Wylie: I would agree with Dr. Langmuir. The fact that we are seeing so many Negro cases is an indication of their economic status. Similarly, the Latin Americans in San Antonio last year and the Amish Mennonites in Missouri this spring probably suffered such high attack rates because of their living conditions.

Dr. Patterson: Are there any questions up to this point from the audience?

Dr. Leslie: Just yesterday I attended a little child who had received one polio immunization along with

a DPT which, according to the mother, was two vaccines combined in one syringe. I understand that this is not advisable. I wonder if that is a factor that has to do with polio cases in supposedly immunized cases?

Dr. Alexander: The only thing that I would agree to is that you have questions about the effects of one immunization edging on the antibody response of the other. As far as these questions go, we don't have any national information on simultaneous administrations.

Dr. Leslie: Am I correct that in DPT there is merthiolate and that merthiolate interferes with the potency of the vaccine. That is, what I had in mind is if you had run into that situation, could it be a factor?

Dr. Wylie: Merthiolate is known to have an adverse effect on the potency of the poliomyelitis vaccine; however, there is a time factor involved. When the vaccines are mixed immediately before use, there appears to be no alteration of the potency of the poliomyelitis vaccine. Such evidence was presented by Batson, *et al.*, at Vanderbilt in the January 1958 issue of *Pediatrics*.

Dr. Langmuir: The Academy of Pediatrics recommended discontinuance of this practice, although I think it is a fairly widespread one and probably is all right. However, you can't be sure. There might be some other antagonistic effect. The quadruple antigens that are now coming out and are beginning to be available in some volume—over a million doses have been distributed—presumably have balanced out this problem, and we can be confident that the company that says one-half cc. dose is sufficient has evidence in their monkey immunization tests that the one-half cc. dose in the regularly prescribed arrangement has provided the antibody response in monkeys above the minimum required. To me this has the enormous future value of becoming a systemized pattern of preventive pediatrics in infancy. It ought to handle our polio problem if we can get it into a really high proportion of the total population, and if we can cover diphtheria, pertussis, and tetanus simultaneously, there is a great future in this.

Dr. Karp: I assume that the data presented by Dr. Wylie is based on clinical information. I wonder if there is any data available from virologically confirmed cases in this vicinity similar to the purely clinical cases.

Dr. Wylie: Since we did not begin to receive large amounts of laboratory results until late fall, our analyses are based on clinical information. However, in 1958, we found similar patterns such as age distribution, vaccination, and paralytic status in laboratory-confirmed cases.

Dr. Graham: If for some reason you have an individual who has exceeded the recommended schedule, what would you suggest?

Dr. Alexander: There are ranges in the recommended doses, but I think that one of the main points is that if you look at the individual and want to give him optimal protection, then it would be best to follow as close to the recommended schedule as you can. At the same time, obviously, a slight variation in the recommended schedule is going to give just about the same response.

Dr. Patterson: Are there other questions? I think the questions ought to be asked from the standpoint of the individual as well as from the public health standpoint. The individual's private physician is belabored now with the questions: What about the fifth injection? How long will protection from the four injections last, or, is protection from three injections in the 75 per cent to 90 per cent order? What range of protection is afforded by, say, four injections and for how long? I think these are particular problems to the man in private practice. In the Atlanta area most of the pediatricians last year gave their patients the fourth immunization. I would say perhaps 80 per cent to 90 per cent of the pediatricians did. Now their patients want to know about the fifth injection.

Dr. Langmuir: Let me answer that right here. Until spring of this year I was known as one of the three-dose men. I admit heartily this was from the public health point of view. Dr. Salk, at the launching of the March of Dimes in Ann Arbor in January surprised everybody, which naturally caused consternation at that moment, when he advocated a fourth dose just at the time that we were about to campaign intensively for getting the first dose into the children throughout the country. From a public health point of view the desirable thing was to start with these unvaccinated children who had not even had their first dose. The Public Health Service was cautious of recommending a fourth dose, for if it were interpreted by many of the news reporters and others that this was finally an admission of the vaccine not being perfect, it would deviate away from the main problem. This was my position. The pediatricians the year before, of course, had come out and recommended the fourth dose and to me there is no problem here. The pediatrician has a patient in his office, and he does what he does for the best interests of this patient. The public health officer, on the other hand, has a community—where does he stress the emphasis first? Now this fourth dose problem is pretty well settled. It is fully recommended everywhere that a fourth dose one year or longer, any

time longer after completion of the first three doses, is desirable. I have seen a fair amount of data on what the fourth dose does: it gives a whopping antibody response in the titres of 500 to 1000. I would think there is no suggestion, no evidence that I know of anywhere, to recommend a fifth dose, except maybe in this new schedule of under six months' starting, when you give three doses and then the fourth dose at seven months, it really is the equivalent of the third dose. A year later a fifth dose, say at two years of age, probably would be a valid part of really complete immunization. I can visualize in some years from now pretty routinely giving a booster on entering school which would be a fifth dose. This would be not so much on sound epidemiological evidence as on a reasonable plan. If you are going to have your child given a pre-school examination, you are going to give him a diphtheria booster, and some people, I think, even advocate a pertussis booster at this time, thus making the booster quadruple. This I can see coming, but I question that we should recommend a fifth dose as a routine on any basis.

Dr. Patterson: Is there any report within the United States from any complications of the vaccine, particularly in reference to the administration of vaccine developed on monkey kidney substrate.

Dr. Wylie: No. There are no documented reports of such reactions. On the contrary, Abelsen, and co-authors, were unsuccessful in demonstrating rhesus antigen in the vaccine by administering it to sensitized Rh negative volunteers. This report was published in the *JAMA*, September 1955.

Dr. Patterson: Dr. Langmuir, Chief of the Epidemiology Branch of CDC, will discuss the live virus vaccines.

Dr. Langmuir: On the subject of live virus, it has been in the newspapers that this is a very rapidly moving field. I have been reasonably active in participating in this, for in May I went with a team to Costa Rica, where a large field trial of the Lederle strains was in progress. We set up a surveillance for safety. At the end of June a week-long conference brought together all of the protagonists and antagonists in this field, including three from Russia, one from Czechoslovakia, one from Poland, and so on. It was a complete world conference with essentially everybody who had worked in the field. Also, I am a member of the Public Health Service Advisory Committee which has been meeting for the last year very intensively planning the requirements for licensing this new and intriguing product. Let me give you the gist of the status of this changing field with the understanding that tomorrow there may well be something that changes some of this.

The benefits of live virus vaccine are several. Some are theoretical and some are rather real. The live virus vaccine as fed gives a tissue immunity and intestinal conditioning that has a great deal more resistance to infection. Whereas, following the Salk vaccination, one is still susceptible to becoming an intestinal carrier. In addition, it is cheap—above and beyond any concept since you make it the same way you make Salk vaccine and then you dilute it 1 to 100. However, this is a largely theoretical benefit because it takes about 25 to 30 cents to fill a vial, so that the cost of what goes into the vial, as with penicillin and so on, is a small part of the total cost of handling, safety testing, and shipping. Then, of course, there is the wonderful benefit of merely feeding a drop, a capsule, one-half cc. in a teaspoon, compared to inoculations.

The liabilities of the live virus vaccine are considerable, also, and presumably can be solved but are not yet fully solved. Back of all this, and what worries me, is safety. How do we know that the vaccine has not been attenuated only partially, so that when received in triple negative susceptible children, one in 10,000 will come down with paralytic disease? We can't get anybody to agree as to what the threshold of safety should be and it may get down to the point where you cannot touch this. That is one of the real problems. Now, then, when you feed a live virus or when you use a live virus vaccine, you have all kinds of additional production problems. How are you sure that it is not contaminated? How are you sure that the seed strain has not reverted or changed or that one of the workers by being a carrier hasn't contaminated the tissue culture with a wild and virulent strain? There are also the problems of wild monkey viruses, which have killed some dozen laboratory workers employed in making the Salk vaccine. This is one of the hazards of laboratory work and one of the fears is that this B virus might get into a batch of live virus polio vaccine. Fortunately, however, this can be tested for rather easily. There is no danger with formalinized vaccine. The problem that has worried most people about live polio virus is reversion to virulence, the change from an attenuated strain to a virulent strain on passage through the human intestines. The vaccine strains are known to spread through family contacts, and might spread to some degree in the community at large. Can we start an epidemic of a wild type of polio from feeding a few people the attenuated strains, the strains having changed back to a virulent form on passage through the human gut? This is a moral question. The British, who are much concerned about individual rights, are very much concerned about this as a hazard, for an epidemic of

polio may be created under circumstances where the recipients were the unwilling participants in a program.

Now a more practical problem to live virus vaccines is the interference phenomenon. If you feed all three types together, one, or sometimes two, will take and the third will not take. You cannot get the complete response that you get from inoculating under the skin. Also Echo viruses, Coxsackie viruses, and a variety of other circumstances not yet well defined result in variable responses. In areas where Echo and Coxsackie groups are very prevalent, you get only a 50 or 60 per cent take-rate, even giving one strain at a time.

There are three main protagonists, Dr. Sabin, Dr. Cox, and Dr. Koprowski. Dr. Koprowski clearly is the founder and leader of this idea of the principle. Dr. Sabin has done the most extensive amount of work and presumably has the best evaluated strains.

Probably 10 to 15 million Russians will have been fed these Sabin strains this year. The Cox strains under Lederle sponsorship are being used throughout South America and are being tested in the range of maybe 500,000 to 1,000,000 children. The Koprowski strains have been tested in the Belgian Congo under a smaller scale study and only the Type I has had any extensive tests.

We now have outlined the idealized requirements, and these have been distributed to the manufacturers. For example, before licensing it must be shown that 100,000 triple negatives have been fed these viruses successfully. The only strain that can come anywhere near this will be the Sabin strain in Russia. I think there will be quite a series of visitors to Russia this fall to make on-the-spot observations. This is just one of the problems that the committee which advises the Surgeon General is going to have to face. However, we are moving rapidly toward licensing, and it seems to me that use in this country is going to come down to the competition of this new, easy to feed, relatively cheap vaccine. One of the most likely ways is to feed all three doses on the delivery table the day of birth and then, maybe a month or so later, give all three doses again to insure infection by all three types. Possibly a third feeding at one year of age, or some system like this, may be practical. I see tremendous benefits in using single strains in an epidemic situation. You could send nurses or volunteers from door to door with a dropper, let it be put into a teaspoon, and in this way cover hundreds of thousands of children in a week, whereas to inoculate would be a major problem. But I see real competition coming between the live virus vaccine and the quadruple antigen, because you are going to be giving diphtheria, pertussis, and tetanus

anyway and you can have polio right along at the same time. This has a certain simplicity to me which is very attractive. You know what you are doing and you have a predictable basis of what the result will be. It will take a great deal more data and more observation before we have a similar basis for live virus vaccine.

- Dr. Patterson:** Are there any other questions?
- Dr. Willingham:** Could the live virus be used as a booster to the other at this time?
- Dr. Langmuir:** Oh, without doubt, without doubt. This has been recommended by many specialists. As to whether it should become a universal practice, I think the reversion to virulence, the safety in the monkeys, and the production problems have to be solved. Then the various methods of use will follow once we have a group policy.
- Dr. Haverty:** How much of a problem is this Echo-Coxsackie business? I have heard of this, too. It seems to me that we are going to have to try testing the stools of every recipient of the live virus to see if the live virus is going to do any good in the first place.
- Dr. Langmuir:** There was a week-long argument in Washington in June about this problem. I suspect that this is far more important in Mexico City, in Medellin, Colombia, and on the Guadalupean Indian reservation in Arizona where it has been demonstrated to an extraordinary degree—30 to 40 per cent of children tested have one or the other of these enteroviruses present. In the Guadalupean Indian village where Dr. Paul, Dr. Horstmann, and their group went in, they actually fed only six Indian children, and only three of the six became infected. They took several thousand specimens and found Type III

poliovirus on the flies throughout the reservation. They also found half a dozen enteroviruses prevalent, and so they assumed that the failure of the Sabin strains to take adequately was due to this interference. We don't have this level of enterovirus elsewhere in this country.

This may not be a problem for us, but it certainly is a problem in the areas where they are now advocating the use of live virus vaccine. I agree heartily that this lack of knowledge and insecurity of knowing whether or not you have protected your patients are going to be a real worry. There are lots of different methods of sterilizing water but chlorine is the one that is best, not because it is the most efficient or the most economical, but because it is one for which there is a very simple test, the orthophthalidine test. You can do this every hour in large city systems and you know where you stand at all times. Such testing is a tremendous asset, pointing up one of the limitations concerning live virus vaccine until we have better experience as to how consistent the live viruses will be in our hands.

- Dr. Davis:** I wonder if you would briefly enumerate the diagnostic procedures, collecting specimens, and so forth that C.D.C. likes in the suspect cases.
- Dr. Wylie:** In addition to a stool specimen collected during the acute phase of the illness, both acute and convalescent blood specimens are necessary. The convalescent blood should be collected at least two weeks after the acute specimen. Dates of collection for all specimens must be included. The laboratory's procedure is to use the blood specimens to neutralize any agents isolated from the stool.
- Dr. Patterson:** We are indeed grateful to these three gentlemen for the information furnished on these timely problems.

Henrietta Eggleston Hospital for Children

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CANCER OF THE STOMACH

Milton F. Bryant, M.D. and William D. Lazenby, M.D., *Atlanta*

*For any significant improvement in prognosis for these patients,
more efficient methods for early diagnosis must be devised.*

SINCE THE ORIGIN OF medical records cancer of the stomach has been recognized as one of the most frequent neoplasms. According to Lawton, et al¹, more than 40,000 persons die annually in the United States from cancer of the stomach. As long as surgery remains the only known satisfactory method of treating or palliating cancer of the stomach, it was felt that a review of the surgical experience with this disease at Grady Memorial Hospital would be of benefit. From a practical standpoint it is not necessary to wait five to ten years to evaluate our present methods of treating cancer of the stomach. Unfortunately death occurs, with or without treatment, in the majority of patients soon after the diagnosis is made. There is general agreement that with our present methods of treating this disease any improvement in results must come through earlier diagnosis while the lesion is still confined to the stomach.

Method of Study

A review was made of all cases of carcinoma of the stomach seen at this hospital between 1948 and 1955. The diagnosis was established by histologic examination or by convincing clinical and laboratory evidence. An effort was made to obtain a follow-up study on all patients; however, in ten patients follow-up study was impossible. Since each of these ten patients had evidence of residual carcinoma at operation, or at the time of subsequent examination in the out-patient clinic, we have assumed that all ten of these patients are dead from recurrent disease.

Results

A total of 129 patients with carcinoma of the stomach was seen during the eight year period of this study. As shown in Table I, only seven patients are now living and well. It is interesting to note that

one patient is living and well seven years after a gastric resection which was considered palliative by the operating surgeon. Two of these patients have had a relatively short term follow-up. Only one patient operated upon in 1954 is living and none of the 16 patients operated upon in 1955 survived to July 1, 1957.

TABLE I
Cancer of the Stomach
129 Cases, 1948-1955

Total Survivors — 7	
1.	7 yrs. 6 mo. survival — operation considered palliative by surgeon
2.	6 yrs. 2 mo. survival — patient is doing well
3.	5 yrs. 10 mo. survival — patient is doing well
4.	4 yrs. 10 mo. survival — patient is doing well
5.	4 yrs. 6 mo. survival — patient has difficulty maintaining his weight
6.	3 yrs. 4 mo. survival — patient is doing well
7.	2 yrs. 7 mo. survival — patient weighs only 85 pounds

The male patients outnumbered the female patients 2:1. The age range was 31 to 88 years with the average age being 62.2 years. Negro patients outnumbered the white patients 2:1; however, the general admissions to Grady Memorial Hospital show approximately the same ratio.

The most common presenting symptoms were weight loss, 85 per cent, and epigastric discomfort, 58 per cent. Weight loss was recorded in pounds in 78 patients with the average weight loss being 31 pounds per patient. Other symptoms frequently noted by these patients were: nausea and vomiting, anorexia, post-prandial fullness, hematemesis, melena, fatigue, and weakness. The average duration of symptoms before diagnosis of the lesion was seven and one-half months. The reason for delay in diagnosis was classified as being due to "patient failure",

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or "doctor failure"*. From the history given by these patients it was found that 40 per cent of the patients had a delay in diagnosis due to "doctor failure".

The most common physical finding on admission was evidence of weight loss which was noted in 90 per cent of the patients. An epigastric mass was palpable in one-third of the patients. In 13 per cent a Blumer's shelf could be palpated on rectal examination and in nine per cent a Virchow's or Troisier's node was noted. Ascites and enlargement of the liver were present infrequently.

Admission hemoglobin levels varied between 2.2 and 18 grams per cent with an average level of 9.9 grams per cent. Gastric analysis was performed in 45 patients; one-third of these had free hydrochloric acid following histamine stimulation, and two-thirds of those tested did not show free hydrochloric acid following injection of histamine phosphate. All but five of the patients had an upper gastrointestinal series and in 15.6 per cent the radiologist reported the defect in the stomach to be characteristic of a benign gastric ulcer or as no pathology found. Gastroscopic examination was performed infrequently.

Table II shows the type of treatment carried out in each patient. Twenty-five patients were seen so late in the course of their disease that operation was deemed inadvisable. Exploratory celiotomy was performed in 24 patients and two patients refused surgery. In 40 patients a palliative operation was performed, either a palliative resection or simple gastroenterostomy. Five of the carcinomas were discovered at autopsy; two of these lesions were unsuspected.

TABLE II
Cancer of the Stomach
Treatment — 129 Cases

Inoperable	—	25
Exploratory Celiotomy	—	24
Gastroenterostomy	—	27
Palliative resection	—	13
Curative resection	—	26
Total gastrectomy	—	7
Autopsy	—	5
Refused surgery	—	2

A radical sub-total gastric resection, performed as a curative operation, was possible in 26 patients. Two of these patients died in the post-operative period giving an operative mortality rate of 7.7 per cent. Seven of these patients, 27 per cent, were living July 1, 1957. The survival time of each of these patients is shown in Table I.

In seven patients a total gastric resection was carried out, as a curative procedure, for extensive

carcinoma of the stomach. Five of these patients died in the post-operative period while one patient survived three and one-half months and another for 17 months before dying of recurrent disease.

The post-operative complications included most of the problems one would expect following a major upper abdominal procedure; wound infection and dehiscence, evisceration, obstruction secondary to inadequate stoma, obstruction secondary to edematous stoma, massive post-operative bleeding, pulmonary embolus, atelectasis, pneumonitis, thrombophlebitis, myocardial infarction, cerebrovascular accident, acute renal failure, and in one patient, hepatic coma.

Discussion

Ochsner and Blalock² report one carcinoma of the stomach for every 265 admissions to Charity Hospital and the Mayo Clinic³ reports one patient out of every 200 admissions to have cancer of the stomach. Of the patients admitted to the Hines Veterans Hospital¹ 0.6 per cent had cancer of the stomach and 4.7 per cent of all the cancer patients had a malignant gastric lesion. If one takes the total number of patients admitted to Grady Hospital during the eight-year period of this study and calculates the incidence rate for carcinoma of the stomach an extremely low incidence rate of 0.071 per cent is found or one cancer of the stomach for every 1,395 admissions. Since Grady Hospital is responsible for the care of acute emergencies arising in an area populated by approximately 1,000,000 people, one would expect the incidence rate for admissions to be somewhat low. In addition, it is known that for both White and Negro the incidence of cancer of the stomach is greater in the northern states as compared with the southeastern states⁴. For an unknown reason the incidence of carcinoma of the stomach varies from country to country. According to the International Vital Statistics for 1949⁵ Switzerland has the highest incidence where 176 per 100,000 population have gastric cancer. The incidence of cancer of the stomach also has an ethnic variation. Japanese men and women are known to have cancer of the stomach more frequently than Caucasians even though both groups live in the same environment. Diet, nutrition, irritation from hot food and drink, emotional factors, occupational history with exposure to diverse chemicals and hereditary predisposition may in some way explain the geographic and ethnic variation of cancer of the stomach. If the causes of geographic and racial variations in the incidence of carcinoma of the stomach can be determined, perhaps a clue to the etiology of gastric cancer will become evident.

At the onset, and for variable periods of time, carcinoma of the stomach is silent. As the tumor grows and encroaches upon the visceral nerves,

* "Patient failure"—patient had symptoms for three or more months before seeking medical help.
"Doctor failure"—patient treated by physician for three or more months before obtaining upper G.I. series.

vague, inconstant symptoms are produced. Continued growth and metastases result in the production of symptoms and signs that make diagnosis relatively simple. With our present methods of treatment, hope for cure when the neoplasm has advanced beyond the stomach is extremely poor. The only hope for improvement in results is earlier diagnosis and prompt surgical extirpation while the lesion is confined to the stomach. Comparison and study of the 32 patients seen in 1954 and 1955 did not reveal evidence that the neoplasms were less advanced than those seen in the first two years of this study—1948 and 1949. Unfortunately it would appear that we were not diagnosing cancer of the stomach any earlier in 1955 than we did in 1948.

Many investigators^{6,7,8,9,10} are studying and evaluating methods of making an earlier diagnosis of cancer of the stomach; however, at the present time we depend largely for diagnosis upon the skill and experience of the roentgenologist. Any patient over age 40 who has digestive complaints, not of a transient nature, should have the benefit of a complete gastro-intestinal series. One must remember that the roentgenologist is not infallible, and the clinician should not be taken off guard by a negative or non-malignant report. Repeat studies are frequently indicated. In this series the opinion of the radiologist was in error 15.6 per cent of the time.

Problem of Differential Diagnosis

The problem of differential diagnosis between benign gastric ulcer and ulcerating gastric carcinoma is unsolved. Some surgeons^{11,12,13,14} suggest that the differential diagnosis is so uncertain that all gastric ulcers should be operated upon promptly. At Grady Hospital a more conservative approach to the gastric ulcer problem has been followed. Every diagnostic method available is used first in an effort to establish the identity of the ulcerating lesion. If, after thorough study, no evidence or suggestion of malignancy is detected, a program of conservative therapy is instituted in the hospital. Following a period of three to four weeks the patient is again re-evaluated. If complete healing of the ulcer has occurred, and if the patient is symptom free, conservative therapy is continued. A final prerequisite to continuance of conservative therapy is close and frequent evaluation of the patient. If the ulcer and/or symptoms recur, surgical treatment is advised. Even with a carefully controlled program a certain number of errors in management will occur.

For carcinoma arising in the distal one-half of the stomach radical sub-total gastric resection has been the operative procedure of choice. The omentum, gastrocolic ligament, first portion of the duo-

denum, gastrohepatic ligament, and lymph nodes about the celiac artery are extirpated along with 75-80 per cent of the stomach. Since neoplastic invasion of the duodenum and proximal stomach pouch has been shown to occur frequently, it is recognized that it is difficult to tell exactly where to section the duodenum and stomach. For certain large carcinomas that extend high along the lesser curvature, and for lesions in the middle or proximal one-half of the stomach, and for infiltrating neoplasms of the linitis plastica type, total gastric resection is recommended if the surgeon believes that complete removal of the carcinoma is possible. Total gastric resection is not recommended as a palliative procedure. Routine total gastric resection or other super-radical operations have not been used for treatment of cancer of the stomach at Grady Memorial Hospital.

Summary

During the eight year period, 1948-1955, 129 patients with carcinoma of the stomach were seen at Grady Memorial Hospital. Unfortunately death occurred in the majority of patients soon after diagnosis was made; only seven patients are now living. It is evident that with our present methods of treatment any improvement must come through earlier diagnosis. It is necessary to consider gastric cancer in all patients who have unexplained and persistent digestive complaints. Carcinoma of the stomach is a curable disease, notwithstanding the gloom and discouragement that are usually associated with statistical studies.

Medical Arts Building

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MORE DOCTORS URGENTLY NEEDED

A SPECIAL COMMITTEE OF consultants to Federal government has recommended what was termed an urgent, essential program designed to maintain the present ratio of physicians in a sharply expanding population.

Dr. Leroy E. Burney, Surgeon General of the Public Health Service, gave his personal approval to the recommendations made by his 22-member Consultant Group on Medical Education after about a year's study. But he said he couldn't indicate yet "the extent to which they can be incorporated" in next year's proposals of the Department of Health, Education and Welfare.

The Consultant Group recommended expansion of existing medical schools and construction of 20 to 24 new ones with Federal help, federal scholarships for medical students, and greater efforts in the field by states, local communities, foundations, individuals, industry, and voluntary agencies.

The Group said the present ratio of 133 doctors of medicine and eight doctors of osteopathy per 100,000 population is "a minimum essential to protection of the health of the people of the United States."

To maintain this ratio the Group said, "the number of physicians graduated annually by schools of medicine and osteopathy must be increased from the present 7,400 a year to some 11,000 by 1975—an increase of 3,600 graduated.

"To meet the country's need for physicians for medical care, teaching, research, and other essential purposes will require an immediate and strenuous program of action by the nation as a whole," the Group's 95-page report stated.

"This program must safeguard and improve the quality of medical education as well as bring about the needed substantial increase in the number of physicians."

The No. 1 recommendation of the Group was for the Federal government to appropriate over the next 10 years funds—estimated at about \$500 million "on a matching basis to meet construction needs for medi-

cal education," including necessary teaching hospitals.

"The Consultant Group is convinced that the nation's physician supply will continue to lag behind the needs created by increasing population unless the Federal government makes an emergency financing contribution on a matching basis toward the construction of medical school facilities," the report said.

The Group also said research grants to medical schools "should cover full indirect costs so that medical schools are properly reimbursed for the contribution of medical education to medical research."

These two recommendations were in line with American Medical Association positions on the matters.

The Group also urged "more generous public and private support for the basic operations of medical schools." Such support, the report added, "must come from many sources, including state and local appropriations, endowments, gifts and grants, universities, and reimbursement for patient care."

Most of the consultants were physicians or educators. They included Dr. Julian Price of Florence, S. C., a member of the AMA Board of Trustees, and Dr. Edward L. Turner, Director of the AMA Division of Scientific Activities.

Highlights of the Group's Report

To maintain the present physician-population ratio, the expected 1975 population of 235 million will require a total of 330,000 doctors of medicine and osteopathy.

There also must be 12,000 entering students in 1971, as against about 7,600 a year now.

"In a very real sense, the needs for physicians cannot be met by numbers alone. They will be met only as an expanded program maintains and enhances the quality of medical education."

The entry of more physicians into research, industrial medicine and similar activities "has made possible much of the progress of modern medicine." But it also has resulted in "relatively fewer physicians devoting full time to patient care."

MALLET FINGER

This is a difficult injury to treat without some residual cosmetic or functional loss.

Darius Flinchum, M.D., *Atlanta*

MALLET FINGER, WITH the characteristic droop of the distal phalanx from disruption of the terminal extensor mechanism, is a well known condition. A sudden blow against the end of the finger, like from a ball, or else striking the finger tip against some object may cause this disorder as well as occasional dorsal laceration over the distal interphalangeal joint.

Pathological Anatomy

Disruption of the distal tendon interferes with the balance of the entire finger. The extensor digitorum communis inserts into the proximal portion of the mid-phalanx. However, bands from this extensor combine with tendinous slips from the lumbrical and interossei along the sides of the extensor hood to extend on to the distal phalanx. The conjoined tendon just distal to the triangular fascia is rather broad and inserts into the proximal portion of the distal phalanx. It is, however, connected with the dorsal capsule of the distal interphalangeal joint. These bands are intricately connected by arcuate fibers across the extensor hood of the finger. Smooth gliding, balance and tension of this entire extensor structure is necessary for completely normal function and appearance of the finger. When the distal extensor tendon is disrupted, the common extensor tendon inserting into the mid-phalanx exerts an undue amount of pull and there occurs some hyperextension of the proximal interphalangeal joint as a result. This can be noted in varying degrees in most all mallet fingers before or after treatment.

Adherence of the flexor profundus for any rea-

son or adhesions of a flexor tendon graft may also produce a flexed position in the distal phalanx. Rheumatoid arthritis sometimes produces a mallet finger deformity as well as other varied deformities in the hand.

Treatment

There are actually two main types of injury in mallet fingers. The most common is a frayed break or stretch through the distal portion of the extensor tendon. Occasionally a laceration is noted. The other type of injury is an avulsion fracture of the proximal portion of the dorsal aspect of the distal phalanx, where the insertion of the distal tendon is pulled off with the bone fragment. The tendon is intact.

Mallet finger in general is an extremely difficult injury to treat without some residual cosmetic or functional loss. The finger must be splinted so as to hold the lateral bands extending through to the distal phalanx relaxed. This is done by holding the proximal interphalangeal joint flexed and the distal interphalangeal joint in extension. It is difficult to hold this relaxation.

Duncan¹ reported 50 per cent failure with plaster immobilization and the plaster frequently came off the finger. Pratt² devised a unique method of internal splinting by extending a Kirschner wire across the distal interphalangeal joint in extension and with the proximal interphalangeal joint held in flexion. The pin extends across and is anchored into the proximal phalanx. It will then hold the finger in the desired position to allow the distal expansion to heal. This method often works well, but has some disadvantages in that much stiffness may remain in the proximal

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MALLET FINGER / Flinchum

interphalangeal joint or the flexor tendons may be injured in the process of wire insertion. Casscells and Strange³ reported satisfactory treatment by immobilizing only the distal interphalangeal joint in hyperextension by transfixion with a Kirschner wire extending across only the distal interphalangeal joint. Nine of their 20 cases had good results when the distal joint was held in hyperextension for a period of three to four weeks.

In reviewing 26 cases of mallet finger treated by various methods in the past three years, only five can be considered normal. Six are good, eight are improved, and one was not helped. Five were not treated.

I am of the opinion that the following methods of treatment are desirable. External splinting with a dorsal and palmar padded aluminum splint holding the proximal interphalangeal joint in flexion and the distal one in extension for six weeks offers the best chance of satisfactory results in younger individuals. In older people, laborers and those apt to have some joint limitation, a Kirschner wire should be inserted across the distal interphalangeal joint to hold this joint in extended position combined with an external aluminum splint to hold the proximal interphalangeal joint flexed (Figures 1 and 2).

The splint is removed after three weeks to allow flexion and extension of the proximal interphalangeal joint. The Kirschner wire can be inserted initially or after three weeks of external splinting. This splinting method of treatment should be done early, within the first week of injury although it can be tried as long as a month after the injury has been sustained. The distal interphalangeal joint should be kept extended for six weeks.

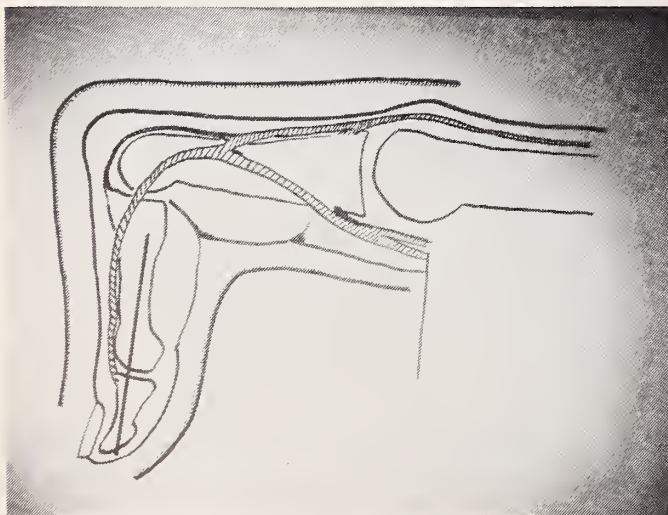


Figure 1: Diagram to show combined external and internal splinting. A small Kirschner wire is inserted across the distal interphalangeal joint combined with external splint to hold relaxation of the extensor bands to the distal phalanx.

In old injury with distal tendon disruption, it must be remembered that the tendon is intimately associated with the dorsal capsule and synovium. The lateral extensor slips have shortened and it is almost impossible to get primary repair in many although with a suture extending through the remaining portion and pulled through a drill hole in the distal phalanx, some approximation may be obtained, but even then some mild residual drooping may be expected. It is improved and appears much better to the physician, but with a slight drooping the patient does not always consider the operation a success. Sometimes a tendon graft is needed across the distal tendon. In any event with repair by pull suture or or some limitation in flexion of the distal phalanx due to the association with the dorsal capsule.

Occasionally, in a few individuals the central extensor communis tendon may be lengthened at its insertion, allowing some flexion of the proximal interphalangeal joint, thus doing away with the compensatory hyperextension and allowing more pull of the lateral bands, which have regenerated to some extent distally. This procedure will allow some lessening of the deformity. If it is not carefully done, however, some adherence of the extensor hood may occur as a complication of the operation.

In recent injuries in which a chip fracture is involved, if good reduction of the fragment cannot be obtained, it is probably best to do an open reduction with fixation of the fragment in anatomical position and restoring the articular cartilage. A larger piece of cartilage may be pulled off with the fragment than suspected by X-ray. A braided wire suture is weaved through the distal tendinous portion and brought through a small drill hole in the distal phalanx, where it is tied over a small roll of Telfa gauze at the finger tip in order to hold reduction and prevent rotation of the fragment. A Kirschner wire is also inserted



Figure 2: Dorsal and palmar padded aluminum splint holds the proximal interphalangeal joint flexed and the distal interphalangeal joint extended.

across the distal joint and the finger splinted with aluminum splints, holding the proximal interphalangeal joint flexed for a period of three weeks and then motion is allowed. At the end of six weeks the wire suture is removed and also the intramedullary Kirschner wire.

In old mallet finger with chip fracture where there is some chronic synovitis and tenderness around the distal joint and most likely considerable disruption of a good portion of the articular surface of the distal phalanx, arthrodesis of the distal interphalangeal joint is the only way of being assured that drooping of the finger will still not persist and also not have associated pain. Even after fusion of the distal joint, some compensating mild hyperextension of the proximal interphalangeal joint may occur, but this will not interfere with function and very little with cosmetic appearance. After arthrodesis of a distal interphalangeal joint, some atrophy in the distal portion of the finger may occur over a period of time.

In some no treatment is necessary or even desirable. The deformity is really not a disabling condition. In others an undesirable cosmetic appearance may result, and in some there may be a painful distal

interphalangeal joint, especially when there is some disruption of the articular cartilage associated with chip fracture. In certain occupations, i.e., typing, a mallet finger can be a real hindrance.

Conclusions

1. Mallet finger is a relatively common injury.
2. It is an extremely difficult condition to treat satisfactorily in that some residual effect may persist. In most all some slight residual drooping or hyperextension of the proximal interphalangeal joint will remain.
3. Best results are obtained by early splinting either external or combined internal and external.
4. Treatment is not required or desirable in all patients with mallet finger.

340 Boulevard, N.E.

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NEW CLINICAL CENTER STUDY ON THE STEIN-LEVENTHAL SYNDROME

AN INVESTIGATION OF THE role of the adrenal gland in the Stein-Leventhal syndrome has been initiated at the Clinical Center, National Institutes of Health. Salient features in this syndrome include oligomenorrhea, hirsutism, and polycystic ovaries.

The cooperation of interested physicians in referring laparotomy-proven cases is invited. Referral letters or phone calls will receive prompt attention and should include detailed medical information about the patient.

Accepted patients will be studied for varying periods up to several weeks. Upon completion of their study, patients will be returned to the care of their referring physician, who will also receive a detailed narrative summary. In some instances it may be desirable to arrange for occasional follow-up visits to the Clinical Center. These would supple-

ment rather than substitute for visits to the patient's own physician.

Physicians interested in the possibility of referring patients should write or telephone:

J. E. Rall, M.D.

Chief, Clinical Endocrinology Branch
National Institute of Arthritis and
Metabolic Diseases
Bethesda 14, Maryland
(OLiver 6-4000, Ext. 4181)

or

Saul W. Rosen, M.D.
Clinical Associate
National Institute of Arthritis and
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Bethesda 14, Maryland
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CONGENITAL TOXOPLASMOSIS: V.

OCULAR ASPECTS OF THE DISEASE

John R. Fair, M.D., *Augusta*

IN THEIR SEARCH FOR the causes of the common inflammations of the inner eye, ophthalmologists were quick to follow up the lead offered by the description of chorioretinitis in congenital toxoplasmosis¹. Attempts to link this infection serologically with chorioretinitis in older children and adults were confused at first by the frequency of past or persistent toxoplasmosis in the general population. After many stops and starts, it can now be said with a fair degree of certainty that:

1. Congenital toxoplasmosis is by far the most common cause of congenital chorioretinitis.
2. Many cases of chronic or recurrent chorioretinitis in older children and adults are only the ocular manifestations of congenital infection.

Of even greater general importance, study of its ocular signs indicates that congenital toxoplasmosis is much more common than previously thought for the reason that in its most common form, only the eyes are seriously involved^{2,3,4}.

Determination of the true incidence of congenital toxoplasmosis becomes increasingly important. If this infection is responsible in large part for the congenital chorioretinitis seen so commonly in ophthalmic practice, then a concerted effort at its prevention should be made. It is the purpose of this paper to describe the typical eye findings in congenital toxoplasmosis with the idea of acquainting the general practitioner, the pediatrician, and other specialists with this important means of diagnosis. The characteristics of the causative organism will be briefly

About one per cent of the general population acquires toxoplasmosis each year.

reviewed along with the principal systemic features of the congenital disease.

The Parasite

Toxoplasma gondii is an obligate intracellular protozoan parasite very widespread in nature having been found in many animals and birds, both wild and domestic. The free and intracellular forms of the organism and its systematic position are shown in Figures 1 and 2. How the infection is transmitted to man (or from man to man) remains unknown. Food, insect vectors, and personal contact with infected animal pets or other humans have all been considered. Laboratory strains of the parasite are maintained by continuous passage in mice.

Human Toxoplasmosis

The congenital form of human toxoplasmosis was the first to be recognized and this only 20 years ago. The earliest cases to be described were those of severe meningo-encephalitis and chorioretinitis with all the consequent clinical features that might be expected, namely: fever, convulsions, hydrocephalus (Figure 3) or microcephaly, muscle palsies, intracerebral calcification (Figure 4), retarded mental and physical development, and poor vision with nystagmus and squint. It soon became obvious, however, that less severe forms of congenital toxoplasmosis existed and now it is realized that its manifestations may be limited to central or peripheral chorioretinitis in one or both eyes. Eye involvement is the most con-

From the Division of Ophthalmology, Department of Surgery, Medical College of Georgia. Portions of this study were supported by grants from the Knights Templar Eye Foundation, the United Cerebral Palsy Research and Educational Foundation, and the United States Public Health Service.

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Figure 1: Free and intracellular form of *Toxoplasma gondii*.

stant feature of the disease which makes its recognition of great diagnostic importance⁵. For example, in a case of convulsions or mental retardation, congenital toxoplasmosis may not be brought to mind except by the discovery of the characteristic healed chorioretinal scars on ophthalmoscopic examination.

To transmit toxoplasmosis to her child, a mother must acquire the infection during that particular pregnancy. Subsequent pregnancies are never affected. As said before, the source or sources of acquired human toxoplasmosis are unknown. Still, the acquired infection is one of the most common of mankind. About one per cent of the general population acquires toxoplasmosis each year⁶. On the basis of this figure, it can be estimated that toxoplasmosis should complicate .75 per cent of all pregnancies. Obviously, congenital toxoplasmosis is not as frequent as these figures would indicate. The gap between the estimated and observed frequencies of the disease has been closed considerably by the recognition of those cases in which serious involvement is limited to the eyes. It may be that certain congenital cases are so mild as to leave no clinical trace of the

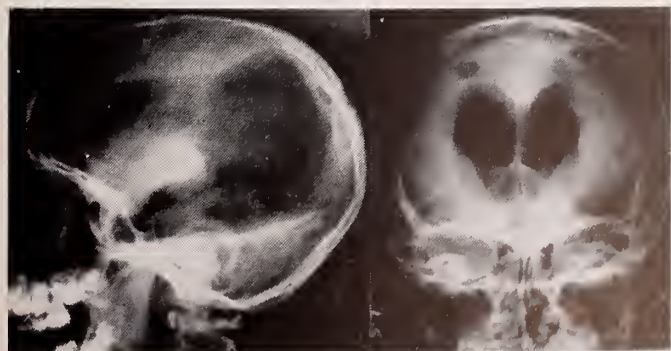


Figure 3: Internal hydrocephalus of congenital toxoplasmosis.

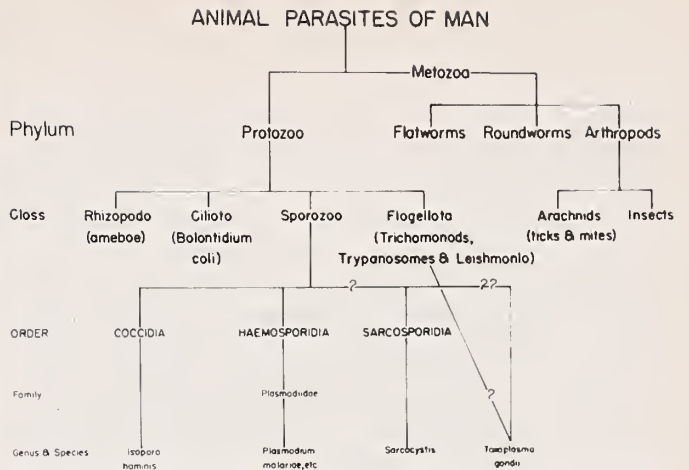


Figure 2: Systematic position of *Toxoplasma*. Its exact relationship to other similar forms is questionable as indicated in the diagram.

disease. It is just as likely that in some maternal infections the parasite fails to cross the placental barrier. For the present, life long chorioretinitis, typically central and often bilateral, is our best diagnostic sign and as such should be familiar to all—general practitioner and specialist alike.

Congenital Ocular Toxoplasmosis

For the purpose of this discussion, the ocular effects of congenital toxoplasmosis may be divided into those outward signs recognizable by the eye unaided and those which require the use of the ophthalmoscope for their detection. The former are less specific than the latter consisting of microphthalmos, nystagmus, and squint, any or all of which may be due to causes other than ocular toxoplasmosis.

Microphthalmos, or congenital smallness of the eye (Figure 5), is the result of developmental arrest, whether due to hereditary influences or prenatal



Figure 4: Intracerebral calcifications of congenital toxoplasmosis.

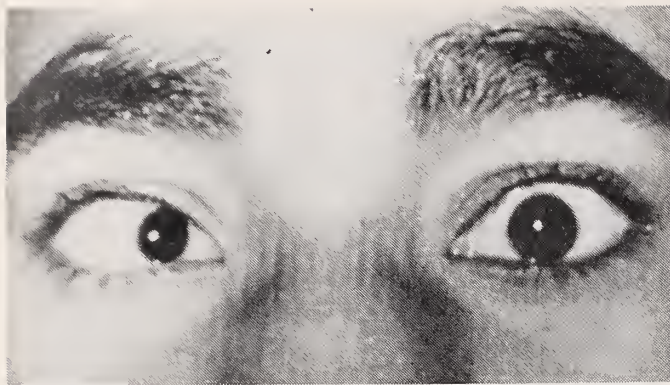


Figure 5: Microphthalmos and internal squint as seen in congenital toxoplasmosis.

intraocular inflammation as is the case in congenital toxoplasmosis.

Nystagmus of the ocular type is always associated with reduced central vision in each eye. Again, it may be caused by any congenital defect which interferes with good visual acuity. The classical example is the nystagmus so constant in albinism but a history of "dancing eyes" since birth should always call to the mind of the examiner the possibility of a bilateral congenital central chorioretinitis, the typical ocular lesion of congenital toxoplasmosis.

Squint, or "cross eyes", again has many causes only one of which is subnormal vision in one or both eyes beginning at or shortly after birth. Every child whose eyes turn in or out or up deserves an ophthalmoscopic examination with the pupils widely dilated as the first step in the investigation of his ocular ailment. A certain number of squints will be found to be due to poor vision resulting from the congenital central chorioretinitis of congenital toxoplasmosis.

In a recent survey⁷ of almost 1,000 children in state schools for the blind in Georgia, South Carolina, North Carolina, and Tennessee, 51 or five per cent of the students owed their visual disability to bilateral congenital central chorioretinitis and of these, a diagnosis of congenital toxoplasmosis was certain or very probable in 40. All showed the nystagmus and squint that call for further examination wherever and whenever such cases are encountered.

Chorioretinitis is a much more specific ocular finding in congenital toxoplasmosis. The presence of bilateral, typically central, focal chorioretinal scars is almost diagnostic of the disease. Characteristically, the macula is involved with disastrous effect on vision. Figure 6 illustrates the appearance of these large pigment ringed lesions which usually are completely healed when found but may harbor viable parasites for 20 or 30 years. Recurrence of the in-

flammation after years of inactivity is especially suggestive of toxoplasmosis.

Examination of Inner Eye

Examination of the inner eye requires familiarity with the use of the ophthalmoscope. The excellent instruments available today leave no excuse for omitting this important part of the general physical examination. Wide dilation of the pupils using 10 per cent phenylephrine (Neosynephrine®) or two per cent homatropine hydrobromide solution or both is required for satisfactory visualization of the fundi especially in young or uncooperative children. High myopia is often associated with prenatal intraocular inflammations so that a strong minus lens must be turned into the aperture of the ophthalmoscope in these cases to focus clearly on the nerve head and retina. Other complicating factors may be incipient or dense secondary cataract and inflammatory exudates in the vitreous either of which may interfere with a good view of the ocular fundi. Wide dilation of the pupils overcomes these obstacles in most cases.

Congenital toxoplasmosis is but one of the systemic diseases which can be diagnosed on the basis of typical eye changes. Routine use of the ophthalmoscope will be of help in some previously unexplained cases of mental retardation⁸ or convulsions when the characteristic central chorioretinal scars of congenital toxoplasmosis are discovered. Conversely, the true incidence of congenital toxoplasmosis and its importance from a public health standpoint will never be appreciated until ophthalmoscopy becomes a part of every physician's routine general physical examination.

Summary

The ocular complications of congenital toxoplasmosis are listed and their diagnostic importance em-

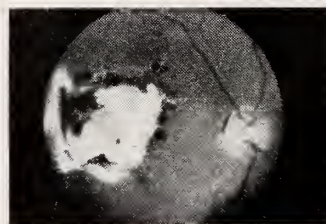


Figure 6a.

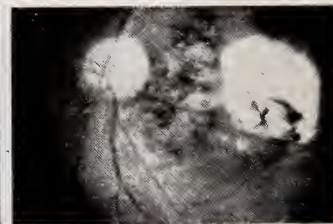


Figure 6b.

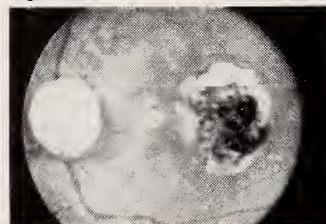


Figure 6c.



Figure 6d.

Figure 6: Chorioretinitis of congenital toxoplasmosis. Healed central (macular) scars are shown in a, b and c. A peripheral lesion is illustrated in d.

phasized. Both general practitioners and specialists are urged to make use of the ophthalmoscope in their routine physical examinations.

Medical College of Georgia

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DO'S AND DON'TS IN WRITING YOUR CONGRESSMAN

"WHY BOTHER WRITING? He'll just throw it in a heap with other letters and send me a form reply." That's the reaction of many people when asked why they don't send their views on legislation to their congressmen.

Nothing could be farther from the truth. Congressmen pay attention to their mail. They have to, because this is their major listening post for voter sentiment.

Carefully Read: And a surprising amount of the letters to congressional offices are read carefully by the congressmen themselves. Those that aren't are handled by key staff personnel who notify their bosses of the contents.

Newspapermen who check lawmakers' offices for stories on how mail from the grass roots is running are often startled at the lawmakers' up-to-date knowledge of who is writing in and about what.

From letters with identical wording, long telegrams signed by lists of people, mimeographed missives, all fall flat. The lawmaker views these as "drummed up" by some pressure group, with in all likelihood many of the signers largely ignorant of what the issue is about. It is the carefully thought-out, individual letter that a lawmaker appreciates.

Courtesy Pays: Threats, shrill warnings, and abuse merely antagonize congressmen. Effective mail is courteous. If the writer feels that he would oppose the congressman if the congressman voted the "wrong way" on an issue, this can be made clear enough without directly saying so. Or if the writer feels that a "right vote" might impel him to an all-out effort to re-elect the congressman, the same applies. Lawmakers realize that this is the democratic way of doing things, and the

only manner in which their constituents can make their voices heard on separate legislation.

Above all, in sending your views to Congress don't fall back on labels or mere catch-word opposition. Set forth exactly why you consider a bill good or bad, how you feel that it would affect you and your neighbors.

Use your own words, not those you have read somewhere.

Another important factor is timing. A flood of letters just as a measure is about to be voted on is much less effective than a single letter months before.

Trends of Mail: The record of a Congress can be determined years later by looking through the mail to congressmen. In the past few years, the tide has run heavily on the need to catch up with Russia's first sputnik; then the recession letters arrived, and now the mail complaining of inflation.

A prime example of mail being a crucial factor was in the passage of the relatively strict labor reform bill last session against what were considered all odds. Mail from businessmen and community leaders had a big role, but even more influential were the letters from individual union members urging approval of the bill. The deluge of "form letters" and the threats contained in some mail from union leaders are a lesson in how *NOT* to persuade a congressman to vote.

Physicians concerned about prospects for approval of legislation to extend social security benefits to provide health care for the aged should note that the most continuous source of mail on Capitol Hill is from elderly persons asking for changes in the Social Security System. Congress has responded by amending the act—at least every election year since 1950.

—*AMA News*

INTERESTING BILIARY TRACT LESIONS

John N. McClure, Jr., M.D., F.A.C.S., *Atlanta*

Specific cases are discussed in this review of the author's experience.

THE PURPOSE OF THIS paper is to review briefly some of the more interesting biliary tract lesions which have been encountered during the past several years.

Congenital Absence of the Gallbladder

A 24 year old student nurse, who had never undergone abdominal surgery, was seen in the Grady Memorial Hospital Student Health Clinic on several occasions because of recurrent right upper quadrant pain, indigestion, and gas. The physical examination was not remarkable except for moderate obesity. Three cholecystograms, the last two with double doses of dye, did not demonstrate the gall bladder at any time. Gastrointestinal series was negative. The preoperative diagnosis of probable cholelithiasis was made and the patient was explored through a right subcostal incision. Upon entering the peritoneal cavity no gall bladder was found (Figure 1). A

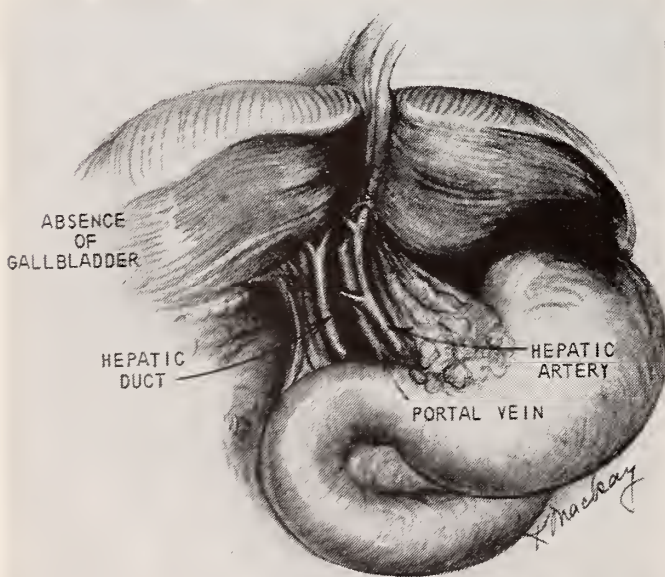


Figure 1: Congenital absence of the gall bladder.

*Presented at the *105th Annual Session of the Medical Association of Georgia, May 18, 1959, Augusta, Georgia.
From the Joseph B. Whitehead Department of Surgery, Emory University School of Medicine, Atlanta 22, Georgia.*

thorough abdominal exploration was made in all quadrants with no other significant findings. The abdominal wound was enlarged in both directions in order to make more room for further exploration. Here, I may digress for just a moment and say that I am a firm believer in the old saying that in biliary tract surgery the length of the incision is directly proportional to the experience of the operator. We made what we thought to be a long incision at the beginning of the operation but since we encountered a situation which was unexpected, we felt that more exposure was necessary. The entire hepatic area was explored as far as possible; the lesser sac, beneath the left lobe of the liver and behind the liver. The entire bile duct was dissected from its origin to its entrance into the pancreas and duodenum. No gall bladder or cystic duct was encountered. The bile duct was normal in size. We did not feel justified in incising the liver in an attempt to find an intrahepatic gall bladder, which occasionally occurs. There was no swelling or inflammation of the liver indicating an intrahepatic gall bladder close to the surface. A T tube was placed in the duct for subsequent cholangiography. The patient had an uneventful postoperative recovery, and a T tube cholangiogram was done on the eighth postoperative day. This revealed normal extra and intrahepatic biliary ducts with no evidence of a cystic duct or gallbladder. The patient was discharged on a weight reduction diet; subsequently lost about 30 pounds, and has done very well since. Interestingly enough, this patient had a fraternal twin sister. It was speculated that the twin might possibly have an absent gall bladder, or a double gallbladder. Cholecystograms were obtained but there was no visualization of her gall bladder. We are anxious to learn the status of this patient's biliary system if she ever undergoes any type of abdominal exploration.

Choledochal Cyst

A colored male infant had a normal birth and

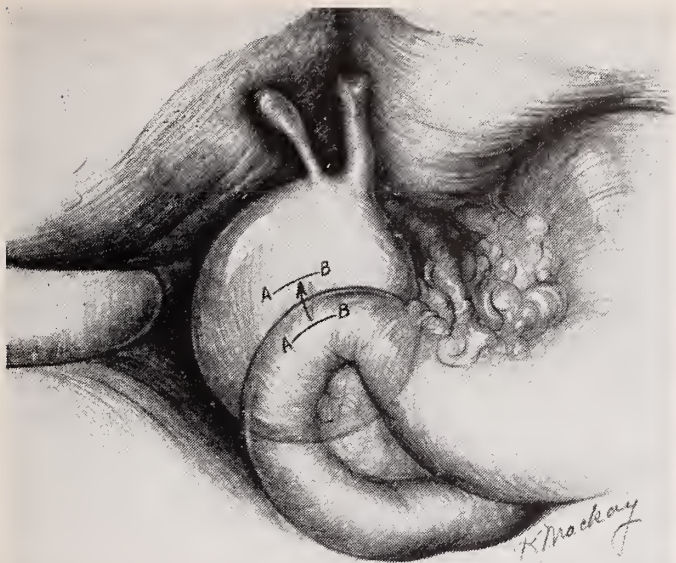


Figure 2: Choledochal cyst.

delivery; was normal size and was noted to be jaundiced at about one month of age. The jaundice progressed; the child was admitted to Grady Memorial Hospital on the pediatric service and was found to have an obstructing type jaundice with acholic stools. At the age of two months, after adequate preoperative preparation, the infant was explored under general anesthesia through a mid-line incision. A large choledochal cyst was encountered filling the entire sub-hepatic area (Figure 2). The cyst was aspirated and found to contain clear bile. Incisions approximately 15 millimeters long were made in the cyst and the duodenum parallel to each other, and an anastomosis made between the cyst and the duodenum. Two layers of sutures were placed; an outer layer of four-0 silk plus an inner layer of four-0 chromic catgut. At the completion of the procedure there was a good opening between the cyst and the duodenum. The infant's postoperative course was uneventful; the jaundice rapidly subsided; he ate and developed normally. The child is now eight years old (Figure 3); has never had any further trouble with jaundice or the cyst and recently was brought back to the hospital for follow-up studies; cholangiograms and G.I. series. Cholangiogram shows a normal functioning gallbladder, apparently with a phrygian cap (Figure 4). The cyst does not visualize. Barium flowing through the duodenum does not pass into the cyst (Figures 5 and 6). Apparently the anastomosis has closed, the cyst atrophied, and the extra hepatic biliary ducts and sphincter are functioning normally.

This is one of the few cases of obstructive jaundice in infants at Grady Hospital which has been surgically correctable. Most of the babies with obstructive jaundice have atresia of the extra hepatic biliary ducts about which nothing can be done, but certain-

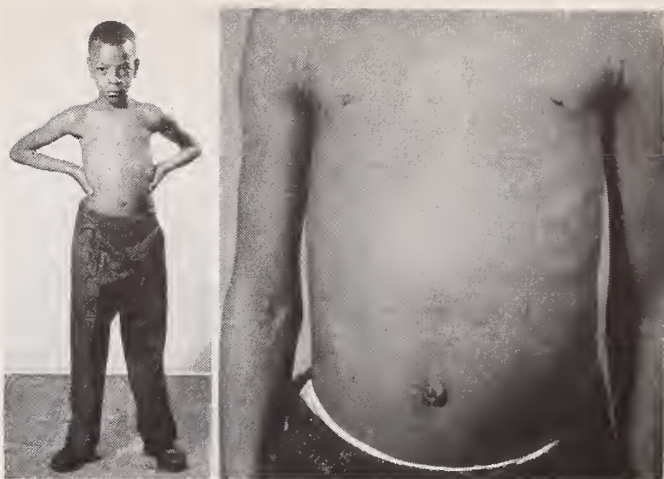


Figure 3: Eight year follow-up of child with choledochal cyst.

ly all such infants should be given the benefit of exploration because an occasional one will be salvaged.

Double Gallbladders

Figure 7 is taken from Gross's textbook and demonstrates the manner of occurrence of different types of gall bladders, which are also rarely encountered. Note that the sixth example of the double gallbladder looks almost like a choledochal cyst. The similarity between this figure and the preceding case is striking. I have never encountered a double gall bladder but am showing this because the question arose in Case No. 1, and because of the similarity of some to choledochal cysts.



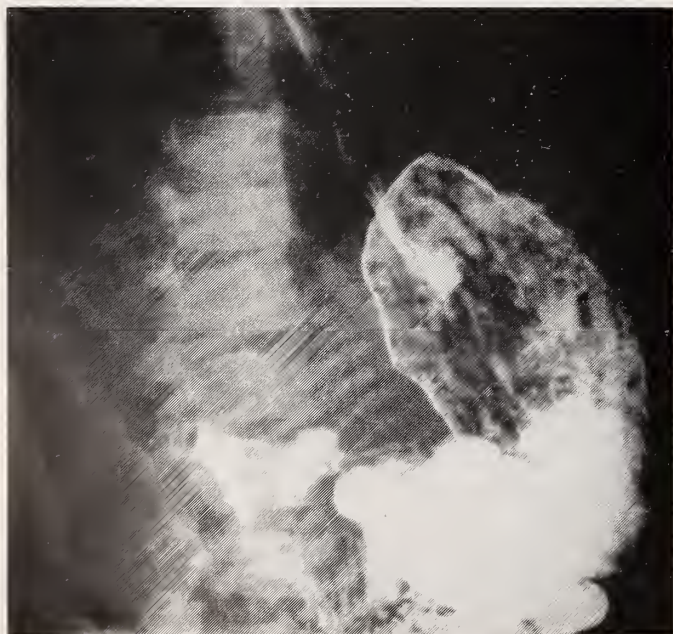
Figure 4: Intravenous cholangiogram of patient in Figure 3.

BILIARY TRACT LESIONS / McClure

Roentgenologists are encountering these lesions more frequently now because they are looking for them more carefully. Ordinarily a papilloma makes a very small faint area of decreased density on the cholecystogram and can be easily overlooked. Figures 8 and 9 show a solitary benign papilloma;



Figure 5



Figures 5 and 6: G. I. series of child with cyst shows no opening between cyst and duodenum.

notice that there is a small stone present adjacent to it. This patient was being thoroughly examined because of minimal and rather vague upper abdominal symptoms of indigestion and gas. However, it is believed that this lesion was completely asymptomatic and was not responsible for the patient's symptoms. I feel that all gall bladders containing papillomata should be removed, provided there is no contraindication to surgery in the patient's general condition. Certainly papillomata or polypae in the remainder of the gastrointestinal tract are removed because of their predelection for malignant change, and the gall bladder should be no exception. There is also the possibility that over a period of time stones will form, or that bits of tissue will break off the neoplasm and pass into the common duct causing jaundice. Because of some confusion in nomenclature these lesions should be called a polypae as pointed out by Shepard, et al.³ This would help distinguish them from cholesterol papillomata which are illustrated in Figure 10. This 30 year old male had repeated attacks of rather severe gallstone colic, and was operated on because of this reason. However, the papillomata were not demonstrable on the cholecystogram preoperatively. The very small stones were seen. This type of lesion is encountered much more frequently than the solitary benign polyp.

Retained Stones in the Common Duct

This patient was a 45 year old male, who also had experienced repeated bouts of gallstone colic. His preoperative roentgenograms are shown in Figure 11. An operation—the gall bladder was removed, the common duct was explored, and eight faceted small stones were removed after flushing and probing the ducts thoroughly. Cholangiograms were made on the operating table in an attempt to demonstrate any further stones. The cholangiograms were read as negative by both the roentgenologist and myself.

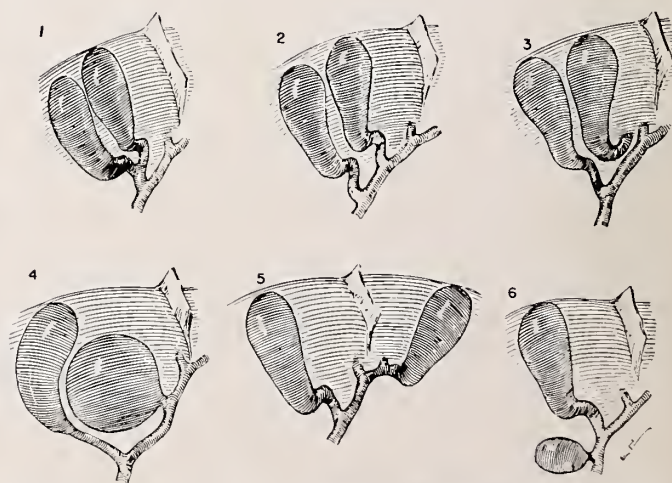
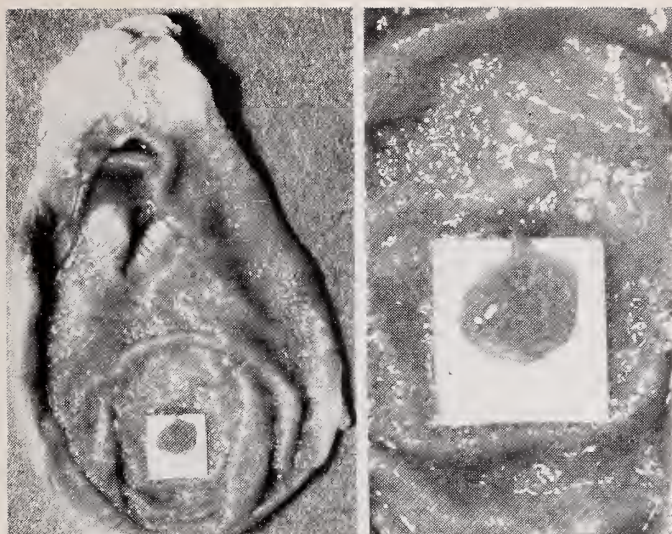


Figure 7: Various types of double gall bladder from Gross's textbook.



Figures 8 and 9: Benign solitary polyp. Close-up of Figure 8. Note small stone at one o'clock.

The patient's postoperative course was uneventful but before leaving the hospital a T tube cholangiogram showed a retained stone in the common duct, as shown in Figure 12. This type of lesion we all encounter more often than we would like. The question arises regarding the treatment of this condition. Actually, if the sphincter has been well dilated at the time of operation and if the patient is placed on cholerrhetics and antispasmodics there is about a 50 per cent chance that the retained stone will pass spontaneously within a reasonable period of time. If the stone does not pass, certainly one is



Figure 11: Preoperative X-ray showing gall bladder stones.

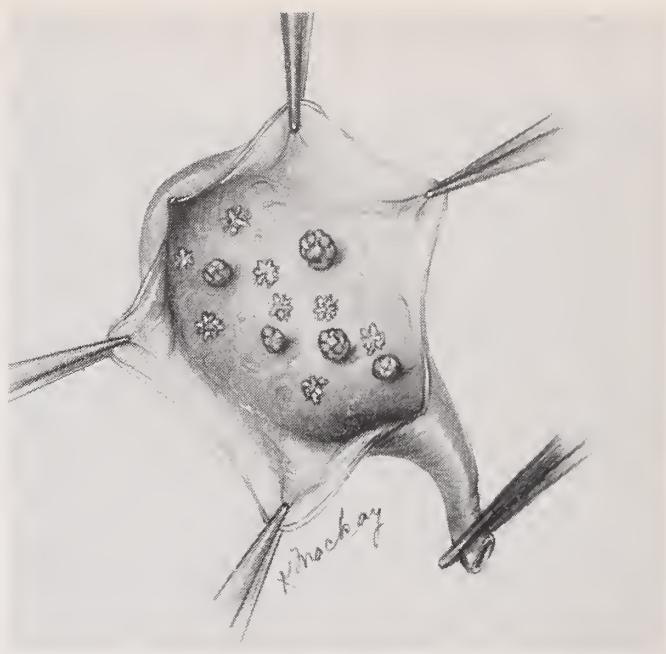


Figure 10: Multiple cholesterol papillomata.

justified in attempting to flush it from the biliary system, using the patient's own bile or normal saline in combination with antispasmodics. If this is unsuccessful, chloroform installations into the common duct through the T tube with the patient in a semi-upright position are very likely to help dissolve the stone, or fragment it so that it will pass. The work of Best and his associates,¹ and Narat,² has shown that the installation of chloroform is a safe procedure provided that the patient does not have extensive liver damage. Best also demonstrated that chloroform was the solvent of choice. Amounts of 5 to 10 cc. cause no damage to the bile ducts and no appreciable injury to the liver, provided the patient is on a high protein, high carbohydrate diet. Any



Figure 12: Postoperative T tube cholangiogram showing retained stone in common duct.



Figure 13: T tube cholangiogram following chloroform flushes. Stone is no longer present.

patient who is to receive such therapy should be well recovered from the operation and on such a diet before this is attempted. If one persists in this approach and has a cooperative patient, many secondary operations can be avoided. Certainly the surgeon as well as the patient rarely likes to participate in another operation of this type. In this particular example as much as 20 cc. of chloroform were instilled into the common duct with to and fro irrigations on several occasions. Nausea and sometimes vomiting was produced but recovery was usually complete within several hours. This particular stone remained present for ten months. The last cholangiogram shows that it was no longer present (Figure 13). There was some question as to whether we wore

the stone out, or whether the stone wore us out; but at any rate the patient was relieved; has had no further difficulty during the past four years. I believe that if one is going to follow the biliary flush routine described by Best, it should be modified appreciably. It is not particularly rational to flush the biliary tract with chloroform and also give the patients antispasmodics. Actually, it should be desirable to have the chloroform in contact with the stone for as long a period as possible. The use of antispasmodics along with this will certainly enable the chloroform to flow out of the bile ducts fairly rapidly. For this reason antispasmodics are not administered when using chloroform irrigations. If one is using only the flush with the patient's bile or with normal saline, then antispasmodics, particularly nitroglycerine, should be used, to relax the sphincter and facilitate the passage of the stone.

Summary

Some interesting biliary tract lesions are reviewed, including congenital abnormalities, papillomata of the gallbladder, and retained stones in the common duct. Comments with regard to the management of these cases are made.

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M. D. RELATIONS WITH PODIATRISTS

THE COUNCIL OF THE Medical Association of Georgia meeting October 10-11, 1959, discussed a communication from the Georgia Podiatry Association stating their interest in clarifying the relationship of podiatry to medicine and suggesting that the American Medical Association Judicial Council Ruling of 1939, which was reaffirmed by the AMA in 1957, be published in the *JMAG*. This AMA Judicial Ruling regarding the status of podiatry to medicine read as follows:

"The Council (AMA Judicial Council) is of the opinion that the practice of chiropody is not a cult practice as is osteopathy, chiropractic or Christian Science which have basis of treatment not supported by scientific or demonstrated knowledge, but on which basis all diseases are treated. Chiropody is rather a

practice ancillary—a handmaiden—to medical practice in a limited field considered not important enough for a doctor of medicine to attend and, therefore, too often neglected. The Council can see no reason to declare the teaching of chiropodists by members of this organization to be unethical, provided the schools in which they teach are connected with approved schools of medicine and recognized standards of pre-medical education are required."

By action of the MAG Council, this request of the Georgia Podiatry Association was approved and referred to the editor of the *Journal of the Medical Association of Georgia* for publication in the interest of providing information to the physicians in Georgia on this matter.

A MOST IMPORTANT CRISIS

Louis M. Orr, M.D., Orlando, Florida

DURING THE PAST 10 years modern medicine has become more and more deeply involved in all the cross-currents of public interest, public opinion, and political action. The American people have become greatly interested not only in the scientific advances of medicine but also in the methods of organizing, providing, and financing hospital and medical services.

On the sidelines, politicians and various legislative manipulators have latched onto medical issues, some with a sincere desire to solve problems, others with both eyes on the ballot box or an ideological goal. And during the same period of time we have seen one large, clear issue give way to a multitude of smaller, more confusing issues.

Late in 1948 and early 1949, the medical profession was facing up to a major threat in the United States Congress. After the 1948 elections it had become apparent that the Truman Administration intended to push strongly for enactment of national compulsory health insurance. So in January, 1949, the American Medical Association, representing the entire medical profession, began its National Education Campaign to defeat that proposed legislation.

The threat was obvious. The issue was clear-cut. The battle lines were drawn. The question was whether or not the American people wanted a form of political medicine for the bulk of the population. Except for a very small minority, the medical profession closed ranks and presented a united front. The great majority of physicians made an effort to study the issue and cooperate in the grass roots campaign. As a result, under the leadership and guidance of the A.M.A., they rallied a tremendous amount of public support for medicine's case.

From 1949 through 1952 the members of Congress could see clearly from the upsurge of public opinion that the people did not want national compulsory health insurance, or any other form of socialized medicine. The proposal never emerged from

In these changing times, a doctor's responsibility does not end with the practice of good medicine. As a responsible citizen, he must be active in the planning for the health needs of our population.

committee, and in the 1950 congressional elections a sizeable number of its most outspoken supporters were defeated for re-election.

It is important to remember that one of our most powerful arguments against compulsory health insurance was the *positive alternative* of voluntary health insurance. Approximately half of the campaign effort was aimed at telling the story of the growth, availability and future promise of the voluntary plans.

Another important point to remember is the fact that even before the National Education Campaign ended in 1952, the proponents of national health legislation began to switch their strategy and tactics. Perceiving that a frontal attack could not succeed, they switched to the more subtle strategy of flank attacks and infiltration. They adopted the "piecemeal" approach and began to split up the so-called omnibus health program into separate bills. Even before our campaign ended, Oscar Ewing proposed Social Security hospital benefits for people over 65, and the first efforts were made to enact the waiver of premium for disabled persons covered by the Social Security program. Other bills began to crop up on such subjects as federal aid to medical schools, disability benefits and various types of expanded government health activities.

At that time your American Medical Association already was warning the profession to beware of the changed tactics by the professional manipulators and their political spokesmen. The A.M.A. urged

Presented to the Fulton County Medical Society and the Fifth District Medical Society, November 5, 1959, Atlanta, Georgia.

MOST IMPORTANT CRISIS / Orr

physicians to remain alert and vigilant to these various side-door and back-door proposals, and to push ahead on the state and local level for positive solutions of all socio-economic problems which might provide ammunition for the advocates of political medicine.

Unfortunately, the profession as a whole tended to relax following the success of the fight against national compulsory health insurance. Even after the 1950 congressional elections, before our campaign was over, many physicians got the feeling that the battle was all won. However, over the past five years or more, the proponents of government medicine have not been relaxing. With far too much success, they have been increasing their efforts to enact various "fringe" proposals—each one of which then serves as a precedent or stepping-off point for still another proposal. The ultimate objective is the full package of government medicine for all.

Number of Bills Involving Medicine on the Increase

From 1944 through 1953 the Congress did not enact a single bill which was opposed by organized medicine, and it adopted numerous measures which received our support. Since 1953, despite the high level of prosperity and the existence of a conservative administration in Washington, we have seen the passage of more medically undesirable legislation than in any other comparable period. And every year the number and variety of bills involving medicine continues to increase. During the 85th Congress that number went over the 700 mark!

Recall for a moment the events of the last few years. In 1954, for example, Congress passed the waiver of premium measure to protect the Social Security of persons who became disabled and unable to earn a living. In opposing this plan—and we certainly were not alone—the A.M.A. argued, among other things, that there were better alternatives not involving medical determination, and that the waiver of premium provision would simply be used as a preliminary to a disability benefits program.

We did not have to wait long for our prediction to come true. The very next year, 1955, the House of Representatives—without holding public committee hearings and with only limited debate on the House floor—jammed through a bill providing the payment of Social Security benefits at age 50 to persons adjudged to be permanently and totally disabled in relation to their ability to work. The Senate postponed consideration of this bill until 1956, which of course was to be an election year.

The Senate Finance Committee disapproved the bill, but when it was brought up on the Senate floor it passed by the narrowest of margins—with the surprising aid of election-year votes from a few supposedly conservative senators.

And, of course, since then we have seen just what was expected—a rash of new proposals to lower or eliminate the age 50 requirement for disability benefits, to establish a program of temporary disability benefits, and so on, *ad infinitum*.

The year 1956 also brought enactment of the Medicare program to provide government-financed hospital and medical care for the dependents of servicemen in the armed forces. Your American Medical Association did not oppose that legislation because it felt that Congress had the prerogative of deciding whether or not such benefits were necessary and proper. The A.M.A. did emphasize, however, that any such program should try to *maximize* the amount of care in *private* facilities and *minimize* the care in *military* facilities. Unfortunately, recent trends have been in just the opposite direction, and are causing increased concern.

VA Hospitals Increasingly More Expensive

There is another type of problem which we face. This kind does not involve new legislation, but rather the subtle, steady expansion of a program already in operation under existing laws and regulations. The major example of this, of course, is the tremendous expansion of the Veterans Administration hospital and medical care program since 1945. We now have more than 22 million veterans, and each year around a half a million are admitted and discharged in VA hospitals. Between 80 and 85 per cent of those discharged each year are patients with non-service-connected disabilities. On any given day close to two-thirds of the VA hospital beds are occupied by non-service-connected cases. Our veteran population is aging, and the cost of the VA medical program is constantly increasing. In 1934 the cost of VA care was 37 million dollars; in 1959 it will be 843 million dollars!

Your American Medical Association believes that VA hospital and medical care should be limited to veterans whose disabilities were caused or aggravated by their military service. We believe this a sound, humanitarian approach and a legitimate obligation of the federal government.

But when such a program is expanded primarily to provide care for a veteran with a disability that occurred *after* his discharge from military service and that has no relation to military duty, then it is time to look closely at the program and at the direction in which it is moving.

In my opinion, this whole problem of veterans' medical care is a vital part of the basic issue of government largesse versus private initiative.

So much for those examples of recent issues. We might think of them as the visible portion of an iceberg—as merely the surface signs of a vast, unseen trend toward increased governmental health activities.

How about the present situation? What do we face today? Despite the great current concern over earth satellites, ballistic missiles, defense spending, economic conditions, and scientific education, we must be alert to all possibilities. In an election year (1960), when the members of Congress can be extremely unpredictable, we must be ready for anything.

Most of you know—I certainly hope so—that the Forand bill, first introduced in 1957, is being considered by the 86th Congress. This legislation would provide certain hospital, surgical, nursing home, and dental benefits to persons receiving Social Security retirement and survivorship payments. The same idea, with numerous variations in benefits and eligibility, will be appearing in many other bills and amendments.

Real Issue Is Basic Principle Involved

The real issue is not the specific provisions of the Forand bill, but rather the basic principle involved. Any Forand-type legislation would raise the same danger. It would add *service* benefits to a Social Security program which so far has been limited to cash payments based on the “floor-of-protection” concept.

This new principle, as you know, would alter the nature of the Social Security program. It would pave the way for evolution of a system of tax-paid health care for the entire population. Every two years—in the even years of federal elections—the push for amendment and expansion would be under way. The continuing trend would first undermine, and eventually destroy, our system of voluntary health insurance and the private practice of medicine.

No action was taken on the Forand proposal during the first session of the 86th Congress. However, it will carry over into the second session. And next year may be a different story. Because of its political appeal, this issue may very well assume “top priority” status in the presidential election year of 1960.

From the defensive standpoint, we must be alert to the strategy and tactics which probably will be employed next year by backers of the Forand bill. For example, we should keep in mind these possibilities:

(1) They will be ready to accept compromises that will water down the bill; (2) they are chiefly interested in establishing a *precedent*, no matter how small, for government-financed health care of the aged; (3) by using the tactics of “divide and conquer,” they will try to prevent the American Medical Association from establishing a united front with the American Hospital Association, the insurance industry and the Blue plans; and (4) to disarm physicians, and lessen the intensity of their opposition, the bill may be amended to cover only hospital and nursing home care.

Every effort will be made to dilute the plan so as to make it more palatable to the hospitals. This strategy may include the suggestion that Blue Cross serve as the fiscal agent for any Social Security hospitalization plan.

To disarm those who are concerned over the potential cost of the Forand bill, the age of eligibility may be raised to 70 as a starter.

If strong opposition to the bill develops, these and possibly other politically expedient changes will be made before it reaches a final vote next year.

This different approach will be more dangerous than any outright attempt to pass the Forand bill as it now stands. A compromise proposal would *appear* to be harmless, and would not open the gate quite so wide right at the start, but it would lead to the same eventualities.

Organized Defense Not Enough

Of course, we must do much more than just organize a good *defense*. We have to show that medicine and voluntary health insurance have a better answer than the kind offered by Forand-type legislation. Our objective is not simply to beat an undesirable bill in Congress. Our major goal is to help our senior citizens help themselves in their various needs.

In the area of voluntary health insurance definite progress already had been made before Mr. Forand emerged on the scene with his version of an old idea. As of 1958, some 43 per cent of the people over 65 wanted and needed health insurance had some form of protection.

For the past year or more, both the Blue Shield Plans and the Health Insurance Association of America have had special committees actively studying means of expanding coverage for older persons. The latter organization, as most of you know, has been urging member companies to offer policies that are guaranteed renewable for life, individual and family coverage for persons already over 65, group coverage that will continue after retirement, and group contracts providing the right to convert to individual coverage when employment is terminated.

MOST IMPORTANT CRISIS / Orr

About three months ago when we testified before the Senate Sub-Committee on Problems of the Aged and Aging, the American Medical Association was able to report that 25 Blue Shield plans in 23 states enrolled persons over 65. In practically all of the other states, medical societies and Blue Shield plans are working out special new programs for the aged. It was also reported—and let me emphasize this—that *all* Blue Shield plans now permit those over 65 to continue their coverage.

During the next nine months or so, many people, including the members of Congress, will be paying close attention to the over-all problems of aging and the aged. And while health insurance coverage for older people is only one phase of this broad sub-

ject, it is—from a timely, practical standpoint—the most urgent field of activity.

In my opinion, the medical profession, the pre-paying plans and the insurance companies must concentrate, in the months ahead, on the development of voluntary coverage for the aged. We must promote, advertise, and publicize new plans and policies. And we must be able to go before the Congressional committee hearings next spring with an even finer story to tell—a story of dramatic growth in coverage, new ideas and approaches, and hopeful outlook for future progress.

If we make that kind of effort—and if we can present a convincing case to Congress next year—I think we may be able to beat back the advocates of governmental action.

1300 Kuhl Avenue

CONQUEST AT BARGAIN PRICES

By Andrew Mashberg
Of The Health News Institute

WHAT PERCENTAGE OF YOUR patients complain to you that the price of medicine is too high? If it's about four out of every ten you're right at the national average.

But, before you decide to agree with these patients, it might be a good idea to take a good long look at the prescription prices to determine why they cost what they do, and whether they really are too expensive.

According to one publication, the average prescription in 1958 cost \$3.08. But, of course, this doesn't really tell the story of prescription prices. This same prescription . . . or one costing \$5 or \$10 . . . often helps physicians cure an illness that 20 or 30 years ago would have cost \$500 or \$1,000. Maybe it was responsible for the patient's survival.

The story of pneumonia is a good case in point. Thirty years ago, according to a survey conducted in Philadelphia, a case of lobar pneumonia meant five weeks in the hospital, out-of-pocket costs of at least \$400, plus lost earnings during hospitalization and convalescence. Total costs: About \$1,000. And one out of every three patients died. Today the average case of lobar pneumonia lasts less than two weeks, does not usually require hospitalization, and only one out of 26 victims dies. Total cost: About \$15 for penicillin or

\$30 for one of the broad spectrum antibiotics, plus the physician's fee.

Mastoiditis is another good example. In 1940, Children's Hospital in Boston reported 305 cases of mastoid abscess. For most of these stricken youngsters, little more than palliative treatment could be administered to ease the agony while they were waiting for a difficult and painful operation which cost up to \$1,000, and often meant partial loss of hearing. Today, many younger doctors have never seen a mastoid abscess. The "expensive" antibiotics permit physicians to control the infection for a cost of \$15 to \$20, and eliminate the need for surgery.

Not only has the cost of illness dropped since the introduction of the modern drugs, but our people spend little more of their disposable income today for medicines than they did 20 or even 30 years ago. In 1929, Americans spent an average of .73 per cent of after-tax income on drugs and sundries. In 1957, that figure had increased to only one per cent despite an increase in the average price of prescriptions from 85 cents in 1929 to \$2.90 in 1957.

Nor has the cost of prescriptions during the postwar inflationary spiral taken as heavy a bite from the American paycheck as many other necessities. Bureau of Labor statistics indicate that medicine cost have risen by only 26 per cent since 1946, compared with 41 per

Reprinted from Memphis Medical Journal.

cent for food, 45 per cent for rent, and 39 per cent for the cost of living index in general.

The clearest indication of the relative decrease in prescription prices can be determined from an examination of the so-called "real price" of prescriptions. That is, the amount of time that the average American has to work to pay for his average-priced prescription.

In 1929, as we have noted, the average price for a prescription was 85 cents. To pay for this, it took one hour and 31 minutes of working time at prevailing wages. In 1958, despite the fact that the average prescription cost \$3.08, it took only one hour and 26 minutes of working time to pay for it.

One of the main reasons for the increases in prescription costs is the steadily rising percentage of sales devoted to research. Out of every dollar received by pharmaceutical manufacturers from sales of medicine in 1958, more than nine cents was plowed back into research and development of new drugs. In 1958, alone, the pharmaceutical industry invested more than \$170,000,000 in research. This represents an increase of 50 per cent over the \$110,000,000 spent on research only two years earlier, in 1956.

One drug corporation executive estimates that "about three years of intensive investigation usually is required before a drug can be judged effective and released for public usage. Furthermore, only one new compound in 500 to 1,000 ever reaches the drug store . . . odds which

no professional gambler would ever take."

More than 8,000 different compounds were screened by one company in the search for isoniazid. Another company studied 34,000 potential antibiotics and 8,000 chemicals in the search for better healing agents. Of the 42,000 products studied, just six were considered worthy of clinical testing.

And, not all of the products which prove clinically valuable turn out to be commercial successes. The story of the multi-million dollar search for pneumonia vaccine which panned out just as the sulfa drugs came along is one example. Another is the story of the synthesis of cortisone from ox bile, which cost millions of dollars to accomplish and which was on the market for only six months before a cheaper process of synthesizing the steroid was discovered by a competitor.

Both the successes and failures of research have contributed to the increased price of new medicines. But, both the successes and failures of research have also contributed to the better health and well being of Americans.

In balance, the cost of medicines must be weighed against our increasing life expectancy; the virtual disappearance of childhood diseases; the plummeting death rate from influenza, pneumonia, and tuberculosis; and the future hope for relief from today's great killers, cancer and heart disease.

GEORGIANS ON PROGRAM OF AMERICAN HEART ASSOCIATION

GEORGIA PHYSICIANS WERE featured participants in the 32nd annual Scientific Sessions of the American Heart Association in Philadelphia, October 23-25.

Dr. Osler A. Abbott, Chief of Thoracic Surgery, Emory University School of Medicine, attended as president of the American College of Cardiology and moderated at the Sixth Session on Clinical Cardiology, Sunday afternoon, October 25. The Session included symposia on cardiac resuscitation and on mechanical methods of assistance to the failing circulation.

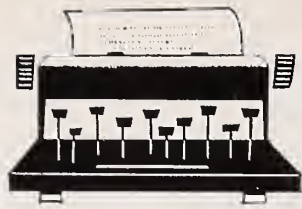
Dr. J. Willis Hurst, Chairman of the Department of Medicine, Emory University, presented the problem for the Symposium on Cardiac Resuscitation.

Dr. J. Edwin Wood, present holder of the Chair of Cardiovascular Research at the Medical College of

Georgia, presented a paper entitled "Peripheral Venous Distensibility in Essential Hypertension" during a session concerning High Blood Pressure Research, Saturday morning, October 24.

Dr. R. Bruce Logue, Professor of Medicine, Emory University, spoke as a panelist during the Symposium on Congestive Heart Failure, Saturday afternoon, October 24.

Dr. J. Gordon Barrow, of Atlanta, immediate Past-President of the Georgia Heart Association, participated in the annual meeting of the American Heart Assembly as a consultant to a discussion of Strokes and the Aging Cardiac. Serving with him on the panel of consultants was M. Linwood Beck, Executive Director, Georgia Heart Association.



editorials

Villa Rica Hospital Wins Georgia Accreditation

IT IS MOST LAUDATORY when true achievement is recognized and due credit for outstanding effort is given. On December 6, 1959 the Villa Rica City Hospital was awarded a Certificate of Hospital Ac-

creditation by the Georgia Hospital-Medical Council. This honor was given in recognition of the excellent standards of patient care provided by the Villa Rica hospital. Such accreditation is gained by voluntary effort on the part of the hospital, its medical staff, governing board, and its administration in maintaining a high quality of patient care.

And therein lies a story that will be meaningful in assuring the people of Georgia of superior patient care by the medical hospital team.

Over a year ago, the Georgia Hospital-Medical Council conceived a program of hospital accreditation for the hospitals of under-25-beds in Georgia. A guide booklet titled "Standards for Smaller Hospitals" was published giving minimum standards for medical, administrative, and physical plant operation. From this broad guide of principles, checklists for inspection teams were developed. It became the aim of the Council to conduct an educational program with the 50 smaller hospitals in Georgia to meet these standards.

Some 35 smaller hospitals have indicated interest in this program which is conducted entirely by Georgia organizations for Georgia hospitals. The Council is controlled and run by representatives of the following sponsoring Georgia groups: Georgia Academy of General Practice; Georgia Chapter, American College of Surgeons; Georgia Association of Hospital Governing Boards; Georgia Chapter, American College of Hospital Administrators; Georgia Department of Public Health; Georgia Hospital Association; and the Medical Association of Georgia.

Georgia Hospital-Medical Council

Certificate of Hospital Accreditation

In Recognition of the Excellent Standards of Patient Care
provided by the

Villa Rica City Hospital

Accreditation Is Achieved by Voluntary Effort on the part
of the Hospital, Its Medical Staff, Board of Trustees and Its
Administration to Maintain a High Quality of Patient Care



This annual accreditation is awarded
by the authority of the Georgia Hospital-Medical Council
composed of the following organizations:

Georgia Academy of General Practice
Georgia Chapter, American College of Surgeons
Georgia Association of Hospital Governing Boards
Georgia Chapter, American College of Hospital Administrators
Georgia Department of Public Health
Georgia Hospital Association
Medical Association of Georgia

The presentation at Villa Rica will mark the first award for accreditation authorized by the Council. After due inspection of the Villa Rica City Hospital, a report by the inspection team was approved by the Council and the certificate was given as a mark of merit. Accreditation is given for a one year period only—and each hospital winning this award will be reinspected annually to maintain this recognition.

Georgia physicians can be justly proud of their

participation in this accreditation activity of the Georgia Hospital-Medical Council. This type program gives meaning to the Association's creed "Guardians of Georgia's Health." It is also noteworthy that inquiries concerning this program have been received from 20 other states and national hospital or medical organizations. The spotlight is on Georgia for leadership in patient care.

The Specialty Boards

THIS IS THE TIME of year when fledgling internists take the written part of the examination offered by the American Board of Internal Medicine. Beads of sweat drop from pallid brows like autumn leaves. Visceral activity is charged by equal amounts of despair and rage. If things run true to form two candidates out of every five will fail. It is fair therefore to ask why about 1,000 of them submit to this torture every fall and by what authority the examiners so operate.

There is no doubt that this is partly mischievous business. There is also no doubt that it serves a useful purpose. The only question is whether the various specialty boards exert more good than harm.

Opponents deplore two of the by-products particularly, although there are other objections also. One is the enormous amount of mental anguish involved to the end that one may have a parchment to hang on his office wall. The more important one accuses the specialty boards of having somehow annointed themselves with the power to decide who may and who may not practice their specialty. The result is that all too many recent graduates seem to be motivated by a desire to qualify as quickly as possible rather than by a simple urge to learn, and that in order to accomodate them a vast system of residencies has grown up which are monotonously alike. Conformity stifles imagination, it is said. The defects are plain for all to see but proponents of the

system are quick to deny that the boards are licensing bodies in any sense of the word. The practice which governmental agencies have of granting advantages in rank and salary to diplomates has been officially denounced by the Advisory Board of Medical Specialties, as has the habit of some civilian hospitals of restricting staff appointments to certified specialists. Admittedly, pressures to conform exists in other subtler guises but there are few professors of medicine, for example, who require their staff members to certify themselves. By the same token, however, it would be a poor teacher indeed who could not pass the examinations if he wanted to take them. Therein lies the heart and the strength of the program—namely, its sole purpose is and has been to encourage postgraduate study. The critic has only to ask himself what would happen to the residency training programs in this country if the various specialty boards were to dissolve tomorrow?

It may also be true that the full impact of the boards upon medical education is yet to be seen. They came into being about 25 years ago because medical schools were disinterested in post-internship training and schools are still content to ratify graduates at only the general practice level. More and better family doctors are certainly needed, but curriculum committees seem not to see that probably 30 per cent of the didactic material now taught to undergraduates might more profitably be postponed

until residency years. There are no *a priore* reasons why formal classwork cannot be continued through the hospital services though this would entail more residents and teachers alike. Deans may well groan at the prospect of 8-10 year curriculums and it might not be entirely wise for schools to offer different

degrees to the generalist and to the specialist, but this is the only obvious substitute for the current board system. Until a better one is adopted critics might try to believe that most examiners are not power-loving sadistic monsters but merely amateurs trying to do a professional job for no personal gain. It remains to be seen whether graduate schools can do a better job of providing specialty education for a sufficient number.

Should Certificates of Death be Amended By Pathologists?

WE SOMETIMES FORGET THAT physicians who sign certificates of death directly influence mortality statistics. The medical certifications entered by attending physicians are used by vital statistics departments all over the world for compilation of mortality data. These data and conclusions drawn from them can be only as accurate as the certifying physician's entry on the certificate of death.

Papers comparing clinical and autopsy diagnoses are few but throw doubt on the accuracy of mortality statistics. We have to ask whether or not this doubt is justified before we answer whether or not certificates of death should be amended by pathologists who examine autopsies.

Some information is available from an investigation that has been pursued at the Medical College of Georgia since the opening of the Eugene Talmadge Memorial Hospital in June 1956. The Division of Vital Records of the Georgia Department of Public Health has been consulted during the study. In this analysis the final pathological diagnoses were compared with the medical certifications (Figure 1) made

by the clinical physicians on the certificates of death (para 22-I-c). Only about half the certificates submitted in cases with complete autopsy were accurate. Inaccuracies arose from incorrect diagnoses and from correct but inadequate diagnoses. The first cause of inaccuracy is apparent: the autopsy established additional evidence that made the clinical diagnosis incorrect. The second cause of error may be less apparent: sometimes the information given was correct but the major underlying disease was not entered. Each of these two causes of inaccuracy might be illustrated by an example: A 45 year old man was thought by his physician to have a brain tumor. If the patient had died before any further studies were done, the death would have been certified as "Brain Tumor" and then have been coded under "Glioma." If the patient had died after exploratory craniotomy but without autopsy, the biopsy would have permitted the death to be certified as "Metastatic Carcinoma, site unknown." However, an autopsy was performed, the primary tumor was found, and this death actually was properly coded as "Bronchogenic Carcinoma." Even though the immediate cause of death (para 22-I-a) might have been the cerebral metastasis, from the viewpoint of mortality statistics and public health it is much more important to know that the underlying disease was a bronchogenic carcinoma.

To illustrate the second cause of inaccuracy, a death was certified due to "Septicemia." This was quite correct, but the amended certificate gave ad-

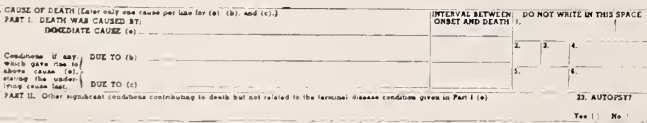


Figure 1: Reproduction of para 22 from the Certificate of Death as currently used in Georgia.

Presented in part at the Annual Session of the Medical Association of Georgia in May, 1959, Augusta, Georgia.
From the Department of Pathology, Medical College of Georgia, Eugene Talmadge Memorial Hospital, Augusta, Georgia.

ditionally the underlying important diseases responsible for septicemia and read: 22. Part I, "(a) septic infarcts of the brain due to (b) acute (staphylococcus) bacterial endocarditis, due to (c) rheumatic fibrosis of the mitral and tricuspid valves."

If about half the certificates of death give incorrect or inadequate mortality data when based on clinical diagnoses alone, it would seem important to amend them whenever new and important information becomes available. Most of this new information comes from autopsy studies. The pathologist is in a position to decide when an amendment is necessary; his decision should be based on all available information both clinical and pathological. Pathologists recognize the difficulties in making clinical diagnoses, and where proper professional relationships exist, pathological diagnoses are made and received as impartial scientific information and without personal invective or criticism.

To what extent the present analysis reflects inaccuracies in death certificates throughout the nation is, of course, not known. Every hospital

population is a selected sample that is not representative of the general population. The large number of unusual and complicated cases in a referral center like the Eugene Talmadge Memorial Hospital distorts the sample even more; operations performed, biopsies and laboratory studies, for example, probably lead to greater accuracy of clinical diagnoses made in hospitals. However, unusual problems lead to more mistaken diagnoses than in a non-hospital practice.

It does seem that conclusions drawn from mortality data would be more reliable if a sufficient sample of medical certifications of death was consistently amended by pathologists when autopsy studies demonstrated the need for correction or clearer specification of the major underlying disease. This sample of amended certificates could then be statistically analyzed to correct the crude mortality data derived from all death certificates. The problem obviously is one for biostatisticians and cannot be entered into here.

Hans J. Peters, M.D.

The Christmas Seal Campaign

LAST YEAR 1,700 Georgians were stricken with tuberculosis. TB killed 267 others. This is quite a revelation to some of us in this age of antibiotics and chemotherapeutic agents. In spite of our advances in surgery and chemotherapy, TB now accounts for more deaths than all other infectious diseases combined.

The National Tuberculosis Association organized in 1904, was the first voluntary organization formed by doctors and laymen to work together against a specific disease. Today it has constituent associations in every state and territory. Affiliated with these are associations organized on a county or city basis. Altogether there are 2,700 voluntary tuberculosis associations joined in a common cause. The Georgia TB Association was organized in 1913. Today there are 63 local affiliates.

The Annual Christmas Seal Campaign supports the work of the tuberculosis associations. Of the money raised each year in local communities 94 per cent remains within the state; the other six per cent is allocated to the national organization. Christmas Seal funds are spent primarily for health education, case finding, rehabilitation, and research. Local affiliates in Georgia retain from 50 to 81½ per cent of the money they raise.

The Christmas Seal Campaign this year was begun on November 16, and will continue through the month of December. It is hoped that all doctors will give generously to this worthy cause. It is also hoped that the doctors of Georgia will alert their acquaintances to the seriousness of the TB problem and the need for their support of the Christmas Seal Campaign.



heart page

EMOTIONAL PROBLEMS IN PATIENTS

WITH CEREBROVASCULAR DISEASE

Morgan E. Scott, M.D., *Atlanta*

BECAUSE OF THE LENGTHENING life span of our population there has been a simultaneous increase in the incidence of cerebrovascular psychiatric problems. Surveys of the first admissions to mental hospitals in Virginia (1956) revealed that 30 per cent were due to cerebrovascular disease; mental hospitals in New York reported an incidence of 22 per cent (1957). An unknown number of neurotic disorders, some psychotic and behavioral disorders due to vascular cerebral afflictions are managed at home or in custodial institutions. It becomes the responsibility of the internist, family physician and frequently physicians in other disciplines to understand types of problems arising in non-hospitalized patients.

Arteriosclerosis itself is a relatively benign process which produces little if any interference in cerebral function. However luminal narrowing or obliteration produced by atherosclerosis is far more serious because of its effect on blood flow. Blood flow limitations can affect delivery of oxygen and metabolites and finally lead to cellular death. Localized damage produced by thrombosis usually results in less severe

mental symptoms. Emotional symptoms due to vessel disease are often vague and insidious.

Fatigue, headache, defects in concentration, and diminution in intellectual function are common early symptoms. Premorbid traits of neuroses, psychoses or personality disorders which have not been clinically manifest may come to surface even with minimal organic involvement. Patients sense the loss of previous emotional, mental and behavioral controls. These losses produce anxiety and compensatory devices to cover up the defects. Social functions and associates are shunned to prevent embarrassment. As the condition progresses periodic confusion, lability of mood, defective judgment and disorientation occurs. Infectious diseases, prolonged bed rest, and stress tend to increase emotional reactions. Change to less stressful environment, control of infections and ambulation may ameliorate emotional problems. Psychotherapy, supported by an understanding physician and drug treatment are of assistance to patients. To illustrate the management of cerebrovascular emotional problems two illustrative cases are given.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Case I

A 74 year old female had a cerebrovascular accident. She recovered without paralysis. After this the patient showed insomnia, marked fears and prolonged crying spells. The patient was phobic—avoiding cooking, shopping, going out alone, and talking on the telephone (all these had been enjoyable before her stroke). At her first interview she whined, cried, and complained that she would never be well. The patient was treated with Placidyl® (ethchlorovynol, Abbott) 200 mgm. at bedtime and Deaner® (methyldamino ethanol, Ricker) 25 mgm. three times a day. She was seen at weekly interviews at which definite assignments were given to her starting with simple suggestions that she answer the telephone when I called. The motive of these suggestions was based on the assumption that the patient was more emotionally than organically impaired. It was three weeks before she could do this. The patient was asked to make cookies and bring a sample. Along with these "assignments" the patient was urged to go shopping (which she now does), and encouraged to resume former activities despite memory loss. She is now much improved and able to go out alone, answer the telephone, shop and cook although she requires reassurance and continuing medication.

This case illustrates a milder variety of organic disorder which can be managed on an outpatient basis with psychotherapy and drugs. Overall progress has been substantial and probably a type of maintenance therapy will be of benefit in future management.

Case II

A 57 year old female formerly lived alone up until a few years past. About five years ago she began to show changes in her personality, memory, and behavior. The patient became irritable, seclusive, with confusion. Most

of the time was spent in her room. At times other members of her family were accused of removing her clothes or other possessions. Fearful reactions occurred even in familiar surroundings, phrases were repeated over and over, and these were progressively more difficult to understand. Her memory showed a marked change, and during the past few weeks or months she had been unable to remember the days events and appeared not to recognize members of the family. Interview with her was unproductive. She spent the whole time mumbling, wandering aimlessly around the room. Her clothes were continually readjusted and she picked at her dress without any definite purpose. She cried at times but could not give any reason for this. Frequently she would go to the door and then return to her seat. The difficulties in managing her in a home were tremendous. It was recommended that she be confined to a mental hospital.

Consideration of the difficulties in supervision, the adverse effects on younger members of the family, and stress on the patient in the home necessitated hospitalization in this case. Tranquilizers were of little benefit.

Summary

Organic brain disorder produced by cerebrovascular disease is discussed. Causes of organic disorders are namely: (1) interference in delivery or transport of oxygen, (2) defects in delivery or transport of metabolites, and (3) cellular damage or death. Organic damage may produce neurotic, psychotic or behavioral disorders. Two cases are cited and their management discussed. Psychotherapy, supportive therapy, and drug therapy are useful in treating these patients.

MEDICAL CARE DOLLAR BUYS LARGE RETURN

E. F. HUTTON, writing in the Houston, Texas, Chronicle, has something illuminating to say about the economics of medical care.

"We gripe about the rising costs of hospital care and doctor's bills," he says. "Because they hit us 'when we are down,' they seem worse than other rising costs of living.

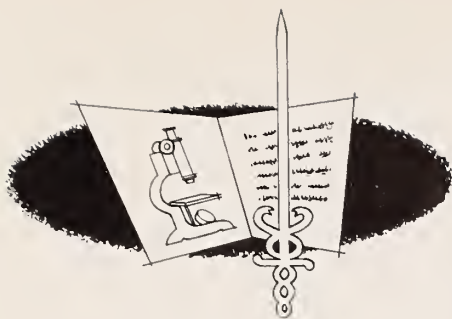
"But there is an unnoticed silver lining. We live longer, stay well longer and get really sick less often than in days of yore. More sick people get well, and get well quicker than in the 'good old days.'

"Modern medicine, surgery, and drugs have added seven years to the average life span since 1940. They have reduced the average length of hospitalization by more than 16 days in the past 20 years, and made rapid cures possible in thousands of cases without going to a hospital. Some dividend!"

There seems to be a more or less widespread feeling that medical care costs have outrun general price increases. That view has been supported by statistical comparisons using base periods which result in a misleading conclusion. A fair comparison presents a very different picture. For instance, in the 20-year 1938-58 period the consumer price index rose 104.8 per cent. Medical care costs rose 99.2 per cent. And physicians' fees rose 83.9 per cent—substantially less than the general index.

Statistics aside, how much are seven more years of life worth? How much is health worth? How much is speedy and complete recovery from illness worth? Such questions are impossible to answer in terms of money. But, whatever one's personal feeling, the medical care dollar buys an enormous return.

—Athens Banner-Herald



cancer page

GEORGIA TO PARTICIPATE IN EPIDEMIOLOGIC STUDY OF CANCER

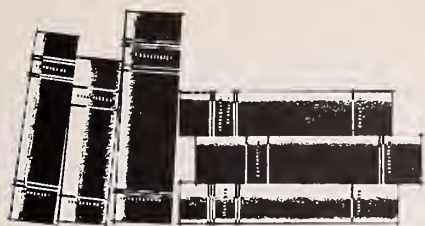
AS REPORTED IN THE July 11, 1959 issue of the *Journal of the American Medical Association*, the American Cancer Society is undertaking a large-scale study of cancer in relation to various environmental factors. The plan is to enroll about 500,000 families nationwide of which about 25,000 will be enrolled in Georgia. Volunteer workers of the Society will be used to enroll families in which there is at least one person over the age of 45 and then request every member who is over the age of 30 to fill out a questionnaire. In order to keep the information confidential, each subject will put his filled-out questionnaire in an envelope and seal it before returning it to the volunteer for transmittal to the research center. The volunteers will not interview the subjects and will not see the completed questionnaires.

The subjects will be followed annually for six years to determine which of them die in this interval. Causes of death will be ascertained from death certificates. When cancer is mentioned on a death certificate, the physician who reported it will be requested to supply additional medical information (e.g., histologic type, stage of disease at time of diagnosis, etc.).

The major purpose of the study is to ascertain the association, if any, between various environmental factors (such as occupational exposures, habits, diet, factors related to the breast and female genital organs, etc.) and the later occurrence of cancer. It is hoped that this will yield clues as to a number of possible causes of cancer.

In addition, it is hoped that the study will provide information of value in relation to lay education. The subjects are asked detailed questions about "present physical complaints" and the answers will be analyzed in relation to cases of cancer diagnosed in the subsequent several months. In order to avoid biasing the subjects, questions are asked about physical complaints which are probably not related to cancer as well as about complaints which may be symptomatic of cancer. Assuming, as is probable, that positive answers to certain of the questions are highly related to the presence of cancer, the data should be of value in persuading people with such complaints to see their doctor immediately. The aim, of course, is to reduce the factor of "patient delay" in the diagnosis of cancer.

Approved by Professional Education Committee, Georgia Division, ACS.



physician's bookshelf

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Smith, Edward B., M.D.; Beamer, Parker R., Ph.D., M.D.; Vellios, Frank, M.D.; and Schulz, Dale M., M.S., M.D., **PRINCIPLES OF HUMAN PATHOLOGY**, Oxford University Press, New York, N. Y., 1959, 1123 pp., \$15.00.

Merrill, Vinita, **ATLAS OF ROENTGENOGRAPHIC POSITIONS**, The C. V. Mosby Co., St. Louis, Mo., 1959, 663 pp., index, \$32.50, 2 vols.

Hyman, Albert Salisbury, M.D., **THE ACUTE MEDICAL SYNDROMES AND EMERGENCIES**, Landsberger Medical Books, Inc., New York, N. Y., 1959, 442 pp., \$8.75.

Clark, William B., M.D., F.A.C.S., **SYMPOSIUM OF GLAUCOMA**, The C. V. Mosby Co., St. Louis, Mo., 1959, 314 pp., 13.50.

Vignec, Alfred J., M.D., **THE EMERGENCY SYNDROMES IN PEDI-ATRIC PRACTICE**, Landsberger Medical Books, Inc., New York, N. Y., 1959, 382 pp., \$9.00.

REVIEWS

Levine, Samuel A., M.D., ScD. (Hon.), F.A.C.P. and Harvey, W. Proctor, M.D., **CLINICAL AUSCULTATION OF THE HEART**, W. B. Saunders Co., Philadelphia, Pa., 1959, 657 pp.

SINCE THE PUBLICATION of the first edition of this book in 1949, interest in the precise auscultation of heart sounds has grown tremendously. Along with this in-

creased interest, the development of improved sound recording equipment has made feasible many active laboratories for clinical research in this long neglected area. Increased experience with congenital heart disease has been effective in explaining the mechanisms of certain sounds and murmurs. This increased activity has brought forth a flurry of scientific papers and several books on the subject. In spite of their zeal, however, these new investigators in this fascinating area of documented auscultation have so far been unable to describe their findings with the clarity and logical simplicity of the present authors whose identification with this field of interest has long been recognized.

This new volume (the second edition) is profusely and beautifully illustrated throughout. Its prose flows with the ease and clarity characteristic of other books authored by Dr. Levine.

This book should be of interest to all doctors but will be especially appealing to those whose particular interest lies in the field of cardiology.

Wilson, Robert Cumming, **DRUGS AND PHARMACY IN THE LIFE OF GEORGIA, 1733-1959**, Foote and Davies, Atlanta, Georgia, 1959, 443 pp., \$6.00.

THE PUBLICATION OF THIS book, written by Georgia's "Father of Pharmacy" has been eagerly awaited by his countless admirers. And no matter how high their expectations, they will not be disappointed. This is truly a notable work.

Although it is destined to be an important reference book in its field, the scope of this document goes far beyond this horizon. The studies of medicine and pharmacy having been practically identical in the state until the last century, the physician will find he is reading a fascinating chronicle of the early days of his own profession. And lovers of Georgia history, not necessarily belonging to either profession, will be delighted with the chapters describing the problems and struggles of the early settlers of the colony. The reproductions of advertisements and notices, from centuries-old newspapers and journals, are priceless.

In the later chapters, the author brings his readers through the middle years of pharmacy into the modern era of "miracle drugs." Along the way, in an outstanding chapter, he tells the stories of ether and

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

PHYSICIAN'S BOOKSHELF / Continued

Coca-Cola and their impact on the history of pharmacy in Georgia. Unfortunately, Dr. Wilson has declined to insert his personal memoirs into the document, but his observations dealing with the last 50 years carry strict authority. For the author, an octogenarian, has written of the history that he himself helped make.

John F. Stegeman, M.D.

Flatt, Adrian E., M.D., THE CARE OF MINOR HAND INJURIES, The C. V. Mosby Company, St. Louis, Mo., 1959, 266 pp., \$9.50.

THIS BOOK CAN BE used profitably as a reference by the general practitioner, the industrial physician, and the orthopedist. It is a small book but covers thoroughly all aspects of infections and trauma to the hand. It is profusely and well illustrated and makes a good reference book. The only undesirable thing about the book is its title, "Minor Hand Injuries"; the book treats with all types of hand injuries, including the most severe and the term minor hardly seems appropriate in the title.

Duncan Shepard, M.D.

Turell, Robert, M.D., DISEASES OF THE COLON AND ANORECTUM, W. B. Saunders Company, Philadelphia, Pa., 1959, 1238 pp., 2 vols.

Diseases of the Colon and Anorectum edited by Robert Turell, M.D., is unquestionably the most valuable and authoritative text on the diagnosis and management of diseases of the colon, rectum, and anus.

Dr. Turell has assembled the most up-to-date information from 82 eminent teacher-specialists, each an authority on the subject he discusses. Each chapter is unusually easy to read, and the text is beautifully complimented throughout by 974 illustrations showing the techniques involved in the diagnosis and management of anorectocolonic disorders, and the step-by-step surgical procedures. The reader will find full information here also on the medical management of various individual disorders of the colon and rectum.

These volumes will undoubtedly displace all other texts with a diagnosis and management of problems in this particular field.

Edwin Lochridge, Jr., M.D.

Nelson, Waldo E., M.D., D.Sc., TEXTBOOK OF PEDIATRICS, W. B. Saunders Company, Philadelphia, Pa., 1959, 1462 pp.

THE POPULARITY OF THIS textbook is attested by the fact that it is now in its seventh edition and again is

written as a practical book for students, pediatricians, and general practitioners.

Years of teaching experience are reflected in this book and the objective is achieved with a noncontroversial approach to diagnosis of disease and treatment. Excellent charts and illustrations are distributed liberally throughout the text. Among the truly notable discussions presented are those on the normal infant and child.

In this revision new sections have been added on Tropical Eosinophilia, Mesenchymal Diseases, The Physician and the Child with a Handicap, and many others. Major alterations have been made in other sections including Drug Therapy, Cerebral Palsy, and others.

This textbook first appeared in 1933 and has remained in a format most practical for those interested in pediatrics. It is an impressive achievement and the editor is assisted by a large and able group of authorities.

This book can be recommended without reservation to medical students, residents, pediatricians, and to practitioners of practically every discipline in medicine.

Preston D. Ellington, M.D.

Potts, Willis J., M.D., THE SURGEON AND THE CHILD, W. B. Saunders Company, Philadelphia, Pa., 1959, 255 pp.

A WELL WRITTEN concise synopsis of the more common surgical procedures performed on infants and young children. There are several sections dealing with the surgeon's relationship with the child during both the preoperative and postoperative periods. Considerable emphasis is placed on the correct psychological approach to all types of children in all age groups. The author stresses the importance of the physician's role in attempting to alleviate the emotional and physical suffering of children during the trying period of their life as a hospital patient. The book is liberally sprinkled with illustrative and provocative examples of many of the points the author makes. Most examples are drawn from the author's immense experience with children and the surgical diseases from which they suffer.

Each chapter is written in clear concise synopsis form with emphasis on diagnosis, treatment and results of the treatment employed by the author. The omission of many of the tiresome surgical technical details make this an ideal book for those who wish to gain the surgeon's viewpoint of surgical illness in children in concise form.

The book is well written and most sections are enjoyable reading with ample evidence of the author's brilliant and humorous personality throughout the book.

J. A. Thompson, M.D.

GEORGIA ASSOCIATION FOR CLINICAL HYPNOSIS

AN ASSOCIATION FOR CLINICAL HYPNOSIS was formed January 1959 at Milledgeville State Hospital, Milledgeville, Georgia and the following have been elected officers of the association: Le Roi Madison, Staff Psychologist, President; Charles Zattau, D.D.S., Vice President; Tillman Vancel, D.D.S., Program Chairman, and Leon Freeman, M.D., Secretary and Treasurer. The

association has about 20 members composed of physicians, dentists, and psychologists. Any interested professional persons may address their inquiries about the association to Dr. Leon Freeman, Secretary, Georgia Association for Clinical Hypnosis, Milledgeville State Hospital, Milledgeville, Georgia.

current clinical concepts

Emergency Clinic Population Increased

PRESTON WADE, in a discussion of a meeting of the Committee on Trauma of the American College of Surgeons, pointed out that a more careful review of the hospital emergency clinic service was indicated and a study was being carried out to establish so-called minimum standards for hospital emergency clinics. In addition it was noted that since World War II the emergency clinic population has increased 400 to 500 per cent for the following reasons:

1. Service has improved.
2. Less expensive than private physicians.
3. Local private physicians frequently refer their own patients to emergency clinics or ask one of their own surgical residents to look after the patient in the emergency clinic once he is set there.

From a talk at the American College of Surgeons meeting held in Atlantic City, N. J., September 28, 1959-October 2, 1959.

Carbon Monoxide Poisoning

SURVIVAL WITHOUT SEQUELAE from severe carbon monoxide intoxication in patients in whom decerebrate rigidity has developed has not occurred according to the literature. A case manifested by high temperature, rapid respiration, profuse diaphoresis, leukocytosis and almost continuous decerebrate rigidity has been successfully treated with hypothermia. The patient recovered completely and without neurologic sequelae. The authors believe that the use of hypothermia warrants consideration for these desperately ill patients.

Craig, T., Hunt, W., Atkinson, R., *New Eng. Jour. Med.*, Vol. 261, No. 17:854-856, October 1959.

Pica and Anemia

IRON-DEFICIENCY ANEMIA was the main abnormality found in 12 children suffering from pica. When treated with iron their pica disappeared within one

to two weeks and has not recurred. Recommends that all children with such perverted appetites be closely examined for anemia.

Lanzkowsky, P., *Arch. Dis. Childhood*, Vol. 34:140, April, 1959.

Prevention of Disasters and Infection

SIR REGINALD WATSON JONES of London, England, emphasized the importance of surgical "no touch" technique and also emphasized the careful personal hygiene on the part of the operating surgeon in general, and specifically, most careful preparation of hands and arms before entering operating room.

Treatment of Otitis

A simple and effective treatment for otitis consisting of systemic antibiotics, thorough cleaning of the ear, followed by application of 10 per cent Mercurochrome® and then sulfadiazine powder. It is believed that the drying effect of the powder is just as important as its antiseptic properties. The results are far better than with any other treatment used by the author.

Linton, C. S., *Missouri Med.* 56:539-542 (May) 1959.

Urine Test for Para-Aminosalicylic Acid

A SIMPLE QUALITATIVE TEST for para-aminosalicylic acid in urine utilizing the appearance of a dark red color and precipitate in urine after addition of Ehrlich's reagent is described. The test should be useful in determining whether therapy is being carried out by the patient.

Lepehne, G. M., *New Eng. Jour. Med.*, Vol. 261, No. 18:909-910, October 1959.

Surgical Lesions of the Neck in Children

IT IS PROBABLY BEST for the surgeon who does occasional pediatric surgery to wait until the child is 14 and 20 months of age and has lost all of his neonatal fat before operating on the neck lesions which one does not believe to be of a malignant nature. It also may be wise when removing a supposed aberrant thyroid to make sure that he looks at the back of the tongue and examines the neck very carefully or he may be removing the only thyroid gland the patient has.

IN THE CASE OF the cricothyroid cyst one must not remove the posterior wall of this or the person may need a permanent tracheostomy. The surgeon will be into the patient's trachea. This can be excised and the posterior wall left intact.

C. Everett Koop, Philadelphia, Pa., from his talk at the American College of Surgeons Meeting in Sea Island, Ga., September, 1959.



abstracts by georgia authors

Brown, Wm. J., M.D. and Bunch, Wm. L., Jr., M.D., Communicable Disease Center, Fulton County Health Department, Atlanta, Georgia, "How Good is the Reiter Protein Complement Fixation Test for Syphilis?," *South. M. J.* 52:783-787 (July) 59.

The authors compare the Kolmer Reiter protein (KRP), the treponemal immobilization (TPI) and the VDRL slide tests using the results of testings at the Venereal Disease Research Laboratory, Chamblee, Georgia, on the same specimen of serum; and summarize the data contained in the article as follows: The KRP test becomes reactive almost as rapidly as the VDRL slide test following infection, maintains reactivity longer than the VDRL slide test, but, given time, will revert to negative in the same proportion as the VDRL slide test; by comparison it roughly parallels the TPI test in the nonsyphilitic, including biologic false positive test, categories.

Cooper, Frederick W., Jr., M.D., and Grady, Edgar D., M.D., Emory Hospital, Atlanta 22, Georgia, "Transaxillary Transpleural Sympathectomy for the Upper Extremity," *Am. Surgeon* 25:644-647 (Sept) 59.

Transaxillary transpleural sympathetic ganglionectomy is a relatively new approach to performing a sympathectomy for the upper extremity. It was originally devised by W. G. Schulze and Professor R. H. Goetz (of Capetown, South Africa). In theory, it is believed to offer the most complete and most permanent method. In actual practice, preliminary observations confirm these beliefs. The transaxillary transpleural sympathectomy is performed by entering the pleural space through the second or third interspace and then excising the inferior half of the stellate ganglion, the 2nd, 3rd, and 4th ganglia and intervening chain.

A transverse incision over the second or third interspace is made from the lateral border of the pectoralis major to the lateral border of the latissimus dorsi. The incision is carried down through the underlying interspace and the pleura is opened. The small rib spreader is inserted into the interspace and the ribs are slowly spread. The apex of the lung is allowed to collapse or is retracted. The pleura is incised over the ganglia. The rami communicantes to T2, T3, and T4 and the chain between T4 and T5 are compressed with silver clips and transected. The rami communicantes from T1 are left intact, since transection of them will produce a Horner's syndrome. The

stellate ganglion will still have a large portion that may be removed below the points of entry to these rami. The lung is re-expanded as the chest is closed.

Kite, J. Hiram, M.D., Emory Hospital, Atlanta 22, Georgia, "Osteochondritic Changes in the Head of the Femur after Reduction of Congenital Dislocation of the Hip," *South M.J.* 52:945-951 (Aug) 59.

One of the causes of the poor results after reduction of congenital dislocation of the hip is the osteochondritic changes which occur in the head. Two hundred and two patients with congenital dislocation of the hips have been reviewed. It has been stated that the osteochondritis was due to the trauma of reduction and the pressure of the head against the acetabulum. For this reason it has been argued that prolonged traction should be used in all cases before reduction. This is easy for charity patients, but expensive for private patients. Nineteen per cent of my patients showed osteochondritis after reduction. This occurred as frequently in those patients who had traction as in those in whom reduction was without traction. The osteochondritis is probably due to atrophy following the long immobilization in casts. If this is true, it is permissible to reduce the hips which can be reduced easily, without traction. Traction will make the reduction easier for those difficult to reduce.

Brown, Wm. J., M.D. and Sunkes, E. J., Communicable Disease Center, Fulton County Health Department, Atlanta, Georgia, "A Recent Study of the Results of Premarital Serologic Testing in a Southern State," *South. M. J.* 52:707-710 (June) 59.

The purpose of the study was to evaluate the casefinding value of premarital blood tests performed by the Georgia public health laboratories from January 1 to July 1, 1957. It includes blood samples of approximately 85 per cent of all Georgia residents married during that period. Of 26,651 tests, 879 (3.3 per cent) were reported as reactive or weakly reactive. Checking records indicated a 7.4 per cent duplication, giving a 3.1 per cent reactivity rate among unduplicated premarital tests. Persons placed under treatment numbered 255 and included 13 individuals in the infectious stages of the disease, with obvious epidemiologic significance. In view of the annual volume of syphilis cases reported in the United States, the economic loss

arising out of disability and premature deaths from the disease and the annual cost of \$46,000,000 for hospitalization of syphilitic insane, it is recommended that the results of this study indicate the importance of the continuation of premarital blood testing.

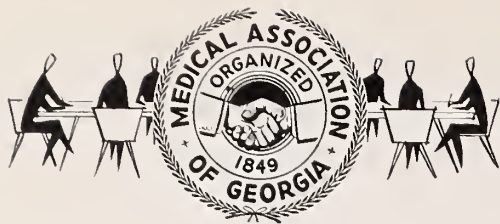
Rooney, Donald R., M.D., Emory Hospital, Atlanta 22, Georgia, "Aberrant Pancreatic Tissue in the Stomach," *Radiology* 73:241-244 (August) 59.

Of the benign tumors of the stomach wall, aberrant pancreatic tissue is one which may possess a distinct gross and radiographic characteristic, thus enabling the correct preoperative diagnosis. These nodules of ectopic tissue may be found at various sites throughout the gastrointestinal tract and elsewhere. 70 per cent of these are located in the stomach and 85 per cent of the gastric nodules are in the antrum or pylorus. Over 350 cases have been reported. Aberrant pancreatic tissue is found in 1.7 per cent of routine autopsies. The most common symptom is non-specific epigastric pain usually ascribed to a peptic ulcer. Pyloric obstruction is the next most common symptom. Other less frequently encountered symptoms include massive gastrointestinal hemorrhage, anorexia or a palpable abdominal mass. The radiologic findings consist of a solitary sharply demarcated round filling defect which is usually immobile. The lesions as a rule measure 1 or 2 cm. in diameter and are located for the most part in the gastric antrum within 6 cm. of the pyloric orifice.

The distinctive characteristic usually present grossly—which we wish to emphasize—is the presence of a central pit or depression. This depression surrounds the orifice of the duct draining the aberrant pancreatic acini. This central duct was demonstrated radiographically and verified grossly in five of the seven new cases reported in this article. When the radiologist finds a rounded sharply demarcated filling defect in the gastric antrum a careful search, aided by pressure spot films, should be made for a central dimple in this nodule. This central depression, when visualized, encourages the correct preoperative diagnosis. The visualization of this structure may be of great value to the radiologist and gastroscopist in the preoperative diagnosis; and to the surgeon or pathologist who may be confronted in the operating room with the decision with the simple vs. radical gastric resection. Radiographs and photographs of this lesion are presented in the article.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Bennett, Wm. F., Jr.	33 Baker St., N.E., Atlanta 3	Active	Fulton
Berry, Joseph N.	3158 Maple Drive, N.E. Atlanta 5	Active	Fulton
Birge, Jack	624 Dixie Street, Carrollton	Active	C-D-H
Branch, David L., Jr.	Doctors Building, Valdosta	Active	S. Georgia
Brew, Barbara Ann	881 N. Highland Ave., N.E. Atlanta	Active	Fulton
Ferguson, Ira A., Jr.	Emory University Clinic, Atlanta 22	Active	Fulton
Gresham, Walter S.	Bowdon	Active	C-D-H
Harper, Henry W., Jr.	Washington	Active	Wilkes
Heilman, Richard B.	1065 Gordon St., S.W., Atlanta 10	Active	Fulton
Hood, E. Walter	30 Collier Rd., N.W., Apt. 12, Atlanta 5	DE 2	Fulton
Hunter, Conway W., Jr.	770 Cypress St., N.E., Atlanta 8	Active	Fulton
Johnson, Janet K.	Beverly Drive, Gainesville	Active	Hall
Johnston, Frank M.	Emory University Hospital, Atlanta 22	DE 2	Fulton
Josey, John S.	340 Boulevard, N.E., Atlanta 12	Active	Fulton
LeLand, Tom W.	2905 Peachtree St., N.E., Atlanta 5	Active	Fulton
Mahue, Louis D.	P. O. Box 291, Hamilton Memorial Hospital, Dalton, Ga.	Active	Whitfield
McCandliss, Robert J.	Milledgeville State Hospital, Milledgeville	Active	Baldwin
Moss, Thomas H., Jr.	409 S. Broad St., Rome	Active	Floyd
Schlant, Robert C.	69 Butler St., S.E., Atlanta 3	Active	Fulton
Wenger, Nanette K.	69 Butler St., S.E., Atlanta 3	DE 2	Fulton
Williams, Julian	Talmadge Memorial Hospital, Augusta	DE 2	Richmond
Woodward, Stephen C.	Emory University Hospital, Atlanta 22	DE 2	Fulton



the association

ANNOUNCEMENTS

Surgeons and related medical personnel are invited to attend the three-day Sectional Meeting of the American College of Surgeons in Louisville, Kentucky, January 21 through 23, 1960. Headquarters will be The Brown Hotel.

The Eighth Postgraduate Course in Diabetes and Basic Metabolic Problems of the American Diabetes Association will be held in Los Angeles, California, on January 20-22, 1960. The Course which is open to Doctors of Medicine is presented under the direction of the Committee on Professional Education of the American Diabetes Association.

Accepted for 18 hours of credit, Category II, by American Academy of General Practice.

For further information write: J. Richard Connelly, Executive Director, American Diabetes Association, Inc., 1 East 45th Street, New York 17, N. Y.

Mid-South Postgraduate Medical Assembly to be held February 9-12, 1960, at the Peabody Hotel, Memphis, Tenn.

DEATHS

WALTER H. CARGILL, JR. of Atlanta, a native of Columbus, died October 26 after a short illness at the age of 40.

Dr. Cargill served as a captain in World War II in the European Theater. He was educated in Columbus schools and Duke University and also studied in Germany.

He was a member of Chi Phi fraternity and Alpha Kappa Kappa, the American Medical Association, Fulton County Medical Society, and the Peachtree Road Methodist Church.

Survivors include his wife; one daughter, Mary Kathleen; one son, W.H. Cargill, III; two brothers, Robert H. Cargill, St. Simons; Douglas B. Cargill, Tallahassee, Fla.; two sisters, Miss Mary Cargill, Obe-

deen, Ohio, and Mrs. Richard Miller, Savannah; and his grandmother, Mrs. Mary H. Dillard, St. Simons.

WILLARD EARL QUILLIAN, SR., 83, who had practiced medicine and surgery in Atlanta for more than 50 years, died at the home of his daughter, Mrs. Robert Thompson of Norwalk, Conn., November 5.

Dr. Quillian was a past president of the International Civitan Club, Atlanta Civitan Club, Medical Association of Georgia, and the Atlanta Board of Health.

He was born at Carrollton and educated at schools in Dalton and LaGrange. He was graduated from Richmond Academy at Augusta and took his AB degree in 1897 at Emory College at Oxford, where he was honor man and commencement speaker. He received his medical degree in 1900 from Washington University at St. Louis, Mo.

Dr. Quillian served during World War I as a captain in the medical corps. He was a charter member of the staff of Emory University Hospital, and had served on the staff of several other hospitals. He had taught for seven years in the old Atlanta School of Medicine.

Survivors include two sons, Willard Earl Quillian, Jr., Greenville, S. C. and Billy Quillian, Augusta; a sister, Mrs. John W. Jones, Ft. Myers, Fla.; and a brother, William Fletcher, Sr., Atlanta.

WILLIAM DAVID WILLCOX died suddenly at the age of 47, October 1 at his home in Fitzgerald.

A native of Irwin County, Dr. Willcox was a graduate of Fitzgerald High School, Emory University, and Emory University School of Medicine. He served during World War II in the medical branch of the U. S. Navy.

For two years Dr. Willcox served as medical director of the Ben Hill County Hospital and was a former chairman of the Fitzgerald Board of Education.

He was a member of the First Baptist Church, Elks, Masons, Ben Hill-Irwin Medical Society, Medical Association of Georgia, and the American Medical Association.

Survivors include his wife; mother, Mrs. E. P. Bowen, Ocilla; two sons, David and Jim Willcox; two daughters, Gail and Diane Willcox, all of Fitzgerald; a brother, Floyd F. Willcox, Moultrie; and a sister, Mrs. R. Q. Duren, Valdosta.

PERSONALS

First District

Doctors that attended the Georgia State Obstetrics and Gynecology Society in Savannah recently were: E. C. DEMMOND, J. J. DOOLAN, JR., J. H. ANGELL, JOSEPH H. McCORMICK, W. L. OSTEEN, D. L. BRAUNER, JULES VICTOR, JR., H. C. FRECH, HOWARD J. MORRISON, and A. J. KELLEY, all of Savannah.

ELLISON R. COOK, III of Savannah was one of the speakers for the 11th annual session of the Georgia Academy of General Practice held in Savannah recently.

LEE HOWARD, JR. of Savannah will serve as chairman for the mayor's advisory committee on health careers for the coming year.

Second District

No News submitted.

Third District

ROBERT A. COLLINS of Americus presented a paper on "Operative Slide Presentation" at a recent meeting of the West Third District Medical Society.

ROBERT H. VAUGHAN, Columbus, has been named president-elect of the Third District Medical Society. FRANK WILSON of Leslie will serve as president and ROBERT COLLINS, Americus, has been elected treasurer.

ROBERT PENDERGRASS of Americus was recently guest speaker at the annual meeting of the American Cancer Society, Terrell County Unit.

Fourth District

ERNEST PROCTOR of Newnan recently attended the 32nd Annual Scientific Sessions, 35th Annual Assembly of Delegates, and Annual Staff Conference of the American Heart Association held in Philadelphia.

W. P. ELLIS of Pine Mountain recently celebrated his 80th birthday.

EDWARD D. WELLS, JR., LaGrange, was among 17 Georgians recently inducted at Atlantic City as a new Fellows of the American College of Surgeons.

J. E. POWELL, JR. and J. I. VANSANT of Villa Rica recently attended a medical convention which was held in Chattanooga.

WILLIS M. HENDRICKS of LaGrange recently attended a postgraduate course in gynecology at Harvard Medical School in Boston.

Fifth District

OSLER A. ABBOTT, J. WILLIS HURST, and R. BRUCE LOGUE, all of the Emory University Department of Medicine, Atlanta, were featured participants in the scientific sessions of the American Heart Association held in Philadelphia recently.

J. WILLIS HURST and WOOD W. LOVELL of Atlanta were speakers at the 11th annual session of the Georgia Academy of General Practice held at Savannah.

Doctors on the program for the Inter-Agency Tuberculosis Committee meeting held recently were: JAMES F. HACKNEY, T. OSCAR VINSON, CLARA B. BARRETT, CARL C. AVEN, WALTER S. DUNBAR, and VIRGINIA McNAMARA all of Atlanta.

J. GORDON BARROW of Atlanta acted as consultant to a discussion of strokes and the aging at a

recent meeting of the American Heart Association held in Philadelphia.

WILLIAM E. SCHATTEN, formerly of the plastic surgery division of Washington University Medical School in St. Louis presented a paper at the annual session of the American Society of Plastic and Reconstructive Surgery held in Miami Beach recently.

Members of a public forum on cancer held recently at the Academy of Medicine in Atlanta were: WILLIAM J. PENDERGRAST, G. LESTER FORBES, MILTON H. FREEDMAN, SAM A. WILKINS, JR., and CALVIN B. STEWART. JOHN T. MAULDIN was moderator.

A. L. MORRIS of Fairburn has been named as a director of the Georgia Academy of General Practice.

L. MINOR BLACKFORD of Atlanta was a featured speaker in a program entitled "Strokes" for the Douglas County Better Health Council held recently.

RIVES CHALMERS, chairman of the Mental Health Committee of the Medical Association of Georgia addressed the Toccoa-Stephens County Mental Health Association at its annual meeting in the Toccoa High School auditorium recently.

THOMAS FORT SELLERS of Atlanta, who is retiring as Georgia's health director after 41 years, was recently featured in the *Atlanta Journal Magazine* section.

HENRY C. JOHNSON of Atlanta has been named Radiologist of Morgan Memorial Hospital.

FLEMING L. JOLLEY of Marietta and Atlanta, was one of 17 Georgians who were inducted as new Fellows of the American College of Surgeons recently in Atlantic City.

HAROLD P. McDONALD of Atlanta recently spoke to the Atlanta Rotary Club on Russian medicine.

Sixth District

DR. and MRS. JAMES W. MURDOCK of the VA Center in Dublin were guests of honor at a farewell dinner given at the Tindol Motel recently. Dr. and Mrs. Murdock left Dublin to make their home in Lake City, Fla.

CHARLES RICHARDSON, JR., of Macon was recently elected president of the Georgia chapter of the American College of Surgeons.

MILFORD B. HATCHER of Macon, president-elect of the Medical Association of Georgia, recently spoke to the Kiwanis Club of Milledgeville.

Seventh District

RAYMOND F. CORPE of Rome recently appeared on the program of the Inter-Agency Tuberculosis Committee held in Atlanta.

DR. and MRS. J. W. WATTS of Bowdon recently entertained at an informal party for DR. and MRS. WALTER S. GRESHAM. Dr. and Mrs. Gresham are newcomers to Bowdon.

Receiving praise from the GHA Committee on Cardiovascular Clinics for their "unselfish support" of the Dalton clinic during the past year were JOHN LOOPER and JAMES A. REDFEARN of Dalton.

HARVEY BEALL and JACK BIRGE, both of Carrollton; WALTER GRESHAM of Bowdon; and IVAN R. ELDER of Bremen were recently welcomed as new members of the Carrollton-Haralson-Douglas Medical Society.

Eighth District

WILLIAM LOOMIS POMEROY of Waycross was recently elected vice-president and president-elect of the Georgia Chapter of the American College of Surgeons.

VILDA SHUMAN of Waycross was guest speaker of the Pilot Club of Hartwell recently.

Ninth District

A. F. BLOODWORTH of Gainesville attended the Tri-State Consecutive Case Conference at Ponte Vedra Beach recently. The conference is sponsored by the Trudeau Society of Georgia, Florida, and South Carolina.

JOHN H. REED, C. W. WHITWORTH, and EUGENE L. WARD of Gainesville attended the American Academy of Ophthalmology and Otolaryngology held in Chicago recently.

A paper, "Diabetes in Children" was recently presented to the Georgia Diabetes Association in Savannah by MARTIN H. SMITH of Gainesville.

Tenth District

CHARLES FREEMAN, JR. and IRA GOLDBERG of Augusta were recently awarded fellowships in the American College of Surgeons at the group's annual convention in Atlantic City.

EDGAR R. PUND of Augusta was the guest speaker at the dinner given recently by the Hospital Authority and the medical staff at the country club in Dublin climaxing the open house of the new wing at the Laurens County Hospital.

An informal panel discussion on geriatrics was led by LOUIS BATTEY, POMEROY NICHOLS, and JULIUS JOHNSON of Augusta for the Junior League of Augusta recently.

ROBERT G. ELLISON of Augusta presented a paper on the "Problems in Diagnosis and Treatment of Abnormal Air Spaces in the Lungs" at the recent bi-annual meeting of the West Third District Medical Society held in Columbus.

SOCIETIES

An award of appreciation from the United Givers Fund was given to Dr. A. M. Phillips recently at a meeting of the BIBB COUNTY MEDICAL SOCIETY.

A gift of \$100,000 worth of medicine was sent to Korea as a result of American generosity. Pharmaceutical firms from throughout the United States contributed the medicine at the request of the COWETA COUNTY MEDICAL SOCIETY.

The FULTON COUNTY MEDICAL SOCIETY and the Atlanta Metropolitan Area of Civil Defense recently sponsored a tetanus clinic where persons could get their first tetanus shot or a booster.

At a recent meeting of the SOUTH GEORGIA MEDICAL SOCIETY, Dr. Richard T. Smith of the University of Florida and Dr. Harry Prvstowsky, also of Gainesville, were guest speakers for the scientific session.

The SECOND DISTRICT MEDICAL SOCIETY recently held a meeting at the Mitchell County Electric Membership Corporation Auditorium in Camilla.

The THIRD DISTRICT MEDICAL SOCIETY recently met at the Columbus Country Club with the MUSCOGEE COUNTY MEDICAL SOCIETY as hosts.

The president of the American Medical Association, Dr. Louis McDonald Orr of Orlando, Florida recently spoke to the FIFTH DISTRICT MEDICAL SOCIETY about the threat of socialized medicine.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE EXECUTIVE COMMITTEE of Council of the Medical Association of Georgia was called to order by Chairman Luther H. Wolff at 10:05 A.M. September 20, 1959 in the MAG Headquarters Office, Academy of Medicine, Atlanta, Georgia.

Members of the Executive Committee present included: Luther H. Wolff, Columbus, Chairman and President; Milford B. Hatcher, Macon, President-Elect; Lee Howard, Sr., Savannah, Immediate Past President; Chris J. McLoughlin, Atlanta, Secretary; J. G. McDaniel, Atlanta, Chairman of Council; and Virgil Williams, Griffin, Chairman of Finance. Also present was Mr. Milton D. Krueger, MAG Executive Secretary.

Reading and Approval of Minutes

The Executive Committee of Council Meeting minutes of July 26, 1959 and August 12, 1959 were read and on motion duly made and seconded these minutes were approved as read.

Professional Conduct Problem

Lee Howard, Sr., presently a member of the Association Professional Conduct Committee, brought to the attention of the members of the Executive Committee of Council that the titled Committee on Professional Conduct Association Bylaws, Chapter IX Section 3D, state: "No member of this Committee shall sit in a hearing involving a physician from his Councilor District." Dr. Howard stated that both he and Dr. C. F. Holton who is the present Chairman of the Association Professional Conduct Committee, should then disqualify themselves in hearings on a particular professional conduct problem brought to their attention by the MAG as such problem concerns a member in their Councilor District. On motion (Hatcher-Williams) it was voted that C. F. Holton and Lee Howard, Sr., be replaced for this particular hearing involving a physician in their Councilor District. The motion further stated that the two next most recent Past Presidents be added to the Committee to make a full Committee of five physicians. President Wolff then appointed Dr. A. M. Phillips, of Macon as member of the Committee and Dr. Enoch Calloway of LaGrange as Chairman of the Committee which already includes Dr. W. Bruce Schaefer, Dr. H. Dawson Allen, Jr. and Dr. William P. Harbin. It was understood that these two appointments were for the hearings involving membership in the 1st District only.

New MAG Headquarters Office Building

Members of the Executive Committee of Council also functioning as members of the Headquarters Office Building Committee inspected the Gulf Life Building and discussed plans for its occupancy by the Association. On motion (McDaniel-Hatcher) it was voted to instruct the MAG attorney Mr. Shackelford to retain all furnishing and equipment that can legally be held as part of the sales contract. The motion further requested Mr. Shackelford to ascertain all property lot lines so that if the bank on the south side of the property was encroached upon by the adjacent property such measures be taken so that

the Association is legally protected in the future from such encroachment.

Secretary McLoughlin brought to the attention of the Executive Committee of Council the information that the building on the north side of the new MAG Headquarters Office property was for sale and on motion duly made and seconded it was voted to reject consideration of the acquisition of such property.

On motion duly made and seconded it was voted that Chris J. McLoughlin and Mr. Krueger draw up an anticipatory plan for utilization of the office space in the new MAG Headquarters Office Building and further that professional advice be sought on this matter if necessary. It was recommended that this report be given at the October Executive Committee of Council meeting.

Finance Committee Report

Finance Committee Chairman Virgil Williams reported on the monthly budget expenditures and income of the Association. On motion (McDaniel-Hatcher) it was voted that the Executive Committee approve this report.

Advisory Committee on Mental Institution Report

Luther H. Wolff, member of the Governor's Advisory Committee on Mental Institutions reported on the activity of this Committee. After discussion of the plans for the Milledgeville State Hospital, Dr. Wolff discussed certain efforts toward construction of a chapel at the State Mental Hospital. By general agreement of the Executive Committee, it was recommended that the Association is sympathetic to endeavors concerning the plans for a chapel at the State Mental Hospital and further the Association sanctions the President's activities in this matter.

Workman's Compensation Liaison

President Wolff discussed a recommendation of the Association Industrial Health Committee Chairman T. A. Peterson, providing that a portion of the program at the MAG Presidents and Secretaries Conference be devoted to a discussion on Workman's Compensation. By general agreement it was recommended that such a portion of the program be devoted to Workman's Compensation with members of the Workman's Compensation Board participating in a panel on this subject.

Public Health Committee

President Wolff discussed the purpose and progress of the Public Health Committee. After discussion of the activities of this Committee it was recommended that this matter be referred to the MAG Council at their October meeting for discussion.

Physicians Fee Schedule Query

A questionnaire from the Medical Journal "GP" concerning the existence of fee schedules in Georgia was discussed. As there was no existent schedule of fees for physicians in the State of Georgia, the matter was referred to Secretary McLoughlin for reply.

MAG Membership Indoctrination

A query from the State of Alabama Medical Association as to whether or not the Medical Association of Georgia had any formal indoctrination for its new membership was discussed. This matter was referred to Secretary McLoughlin for reply and it was recommended that Dr. McLoughlin study the possibilities of instituting such a program of indoctrination for new MAG members.

Glynn County Constitution and Bylaws

Mr. Krueger brought to the attention of the Executive Committee of Council a revised copy of Glynn County Medical Society Constitution and Bylaws. It was pointed out by Dr. Howard that Glynn County Medical Society had already received a charter from the State Medical Association and their revised Constitution and Bylaws does not need Council approval, in that it is merely a revision based on their original Constitution and Bylaws submitted to Council at the time of charter.

Distinguished Service Award Report

Chris J. McLoughlin reported on progress in designing the MAG Distinguished Service Award Medalion and Ribbon. A sample of the sketch of the design of the medalion was submitted on motion (Williams-Howard) it was voted that the design is approved as submitted and that the awards should be purchased as outlined by Secretary McLoughlin.

Headquarters Office Report

Mr. Krueger reported on the complete activity of the American Medical Association in regards to Forand-type legislation. This report was received for information and it was recommended that a full report of the AMA St. Louis October 2-3, 1959 meeting be given at the October Council meeting.

Unfinished Business

Secretary McLoughlin reported that the Association's recommendation for a candidate for "Presidents Committee on Employment of the Physically Handicapped" award was not in order with the requisite of this award. It was recommended that the Association withdraw this nomination and so approved.

New Business

By general agreement the date and site of the next meeting of the Executive Committee of Council was set for October 10 immediately following the Council meeting at Calloway Gardens, Pine Mountain, Georgia.

By general agreement it was further recommended that the Podiatry Association request be referred to the MAG Council meeting of October 10-11.

There being no further business the Executive Committee of Council adjourned at 1:15 P.M.

MEDICAL ASSOCIATION OF GEORGIA COUNCIL MEETING

THE MEETING OF THE Medical Association of Georgia Council was called to order at 2:35 P.M. by Council Chairman J. G. McDaniel on October 10, 1959 at the Gardens Motel, Pine Mountain, Georgia. Dr. McDaniel then gave the opening invocation.

Council members present were: Luther H. Wolff, Columbus, Milford B. Hatcher, Macon; Chris J. McLoughlin, Atlanta; W. P. Rhyne, Albany; Henry H. Tift, Macon; C. H. Richardson, Sr., Macon; J. W. Chambers, LaGrange; Thomas W. Goodwin, Augusta; Charles T. Brown, Guyton; George Dillinger, Thomasville; W. G. Elliott, Cuthbert; Virgil Williams, Griffin; J. G. McDaniel, Atlanta; Charles S. Jones, Atlanta; George Alexander, Forsyth; W. H. M. Weaver, Macon; Ralph W. Fowler, Marietta; Ralph N. Johnson, Rome; F. G. Eldridge, Valdosta; C. R. Andrews, Canton; Paul T. Scoggins, Commerce; David R. Thomas, Augusta; Raymond Arp, Atlanta, Edgar Woody, Jr., Atlanta; John P. Heard, Decatur; Charles S. Johnson, Field Representative, American Medical Association; and Bob Alston, Atlanta.

Mr. M. D. Krueger, Executive Secretary, read the minutes of the Medical Association of Georgia Council meeting of July 25-26, 1959 and the minutes of the Executive Committee of Council meeting of July 26, 1959; August 12, 1959; and September 20, 1959. On motion duly made and seconded these minutes were approved as read with the recommendation that in the Executive Committee minutes of September 20, 1959 the word "bank" used in connection with possible encroachment on the new MAG Headquarters Office Building property be changed to the word "embankment."

Introduction of New Councilors

Chairman McDaniel called on Councilor George Alexander of Forsyth who introduced H. G. Weaver as the new Vice-Councilor for the Sixth District. Mr. McDaniel then called on Councilor Ralph W. Fowler of Marietta who introduced Dr. Ralph N. Johnson as the new Vice-Councilor for the Seventh District.

Board of Medical Examiners Resolution

In general discussion it was recommended that the Association Legislative Committee consider the suggestion that members of the Board of Medical Examiners be chosen from each District for equal representation throughout the State. It was stated that the Legislation Committee would take this matter up with the present Board of Medical Examiners within the near future.

Public Health Committee Activity

President Wolff reviewed the status of the MAG Public Health Committee. He discussed the duties of the Committee and on motion (Elliott-Brown) it was voted that the problem of activating this Committee be discussed with the Chairman of the Committee and further that the President be authorized to make any

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*Hirsch, H. A., and Finland, M.:
New England J. Med. 260:1099
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new appointments, if the present Committee Chairman or Committee members do not wish to serve in their present capacity.

Finance Committee Report

Virgil Williams, Chairman of the Association Finance Committee reported on the Association Budget giving in detail the income and expenditures to date of the Association. On motion (Dillinger-Hatcher) it was voted to approve the Finance Committee report on Budget.

Insurance Committee Report

MAG Insurance Chairman David R. Thomas introduced Messrs. Bragg and Lord of the Life of Georgia Company and Mr. Robert Alston of Dorsey-Alston Insurance Company. Dr. Thomas reviewed the background of the proposed \$10,000 Provident Life Insurance Plan for the membership which was to replace the present \$5,000 Provident Life Plan. Dr. Thomas related that at the October 4, 1959 meeting of the Insurance and Economics Committee, the advice of Mr. Alston was sought and that the Life of Georgia Insurance Company made a presentation on a life insurance program in the amount of \$10,000 a health and accident program, and a hospital-nurse catastrophic insurance program. Dr. Thomas then related the MAG relationship with the insurance advisers.

Dr. Jones reported on the October 4 meeting and the recommendation of the insurance committee at that time. Mr. Krueger was asked to read the recommendation of the Insurance Committee made at their October 4 meeting which is as follows: "It was moved (Jones-Hammett) and voted to recommend to the Council of the Medical Association of Georgia that the Association transfer its MAG-Provident Life Insurance Company term life group policy; health and accident group policy; and catastrophic hospital-nurse group policy to the Life of Georgia Insurance Company, provided the Life of Georgia Insurance Company eliminates the two exclusions about duplicate coverage and, further, provided that the Life of Georgia Insurance Company will assume full responsibility for coverage of any MAG member now carrying any of these three plans of insurance underwritten by Provident during the Life of Georgia Insurance Company normal enrollment periods."

After an explanation of this action and the Life of Georgia Insurance Company insurance programs for the MAG membership, it was moved (Goodwin-Dillinger) and voted to approve the Insurance & Economics Committee recommendation of October 4 concerning the transfer of the three insurance programs to the Life of Georgia Insurance Company. After general discussion of this motion, the motion was approved with the understanding that the agreement with the Life of Georgia Insurance Company would provide for annual review and mutual participation in the program's experience.

Library Bequeathment

Secretary Chris J. McLoughlin reported that he had received a letter from Mr. Edward B. Liles, Attorney in Brunswick, Georgia regarding the will of the late Dr. J. W. Simmons. This will stated that his library was jointly willed to the Medical College of Georgia and the Medical Association of Georgia. Dr. McLoughlin stated that he would have an opportunity to inspect this library and on motion duly made and seconded Secretary McLoughlin was authorized to act for the Association on this matter. This motion was then approved.

Georgia Podiatry Association Request

Secretary Chris J. McLoughlin read a communication of August 26 from E. Dalton McGlamry, D.S.C. Secretary of the Georgia Podiatry Association. This letter stated, in the interest of clarifying the relationship of podiatry to medicine, that the Georgia Podiatry Association requested the *Journal of the Medical Association of Georgia* to publish the AMA Judicial Council ruling of 1939 that was reaffirmed by the AMA in 1957 regarding the status of podiatry to medicine. Dr. McLoughlin stated this was a request to provide information to the physicians in Georgia on this matter. Dr. McLoughlin then read the 1939 report of the AMA Judicial Council as follows:

"The Council (AMA Judicial Council) is of the opinion that the practice of chiropody is not a cult practice as is osteopathy, chiropractic, or Christian Science which have basis of treatment not supported by scientific or demonstrative knowledge but on which basis all diseases are treated. Chiropody is rather a practice ancillary—a handmaiden to medical practice in the limited field considered not important enough for a doctor of medicine to attend and therefore too often neglected. The Council can see no reason to declare the teaching of chiropodists by members of this organization to be unethical, provided the schools in which they teach are connected with approved schools of medicine and recognized standards of pre-medical education are required."

On motion duly made and seconded this request of the Georgia Podiatry Association was approved and referred to the Editor of the *Journal of the Medical Association of Georgia* for publication.

Workman's Compensation Medical Board Appointments

Secretary Chris J. McLoughlin read a communication of October 1, 1959 from Henry G. Neel, Assistant Attorney General, Executive Department, State of Georgia. This communication stated that Section 114-822 of the Code of Georgia provides for the appointment of a Workman's Compensation Board by the Governor and provides further that as and when vacancies occur, the Medical Association of Georgia shall nominate to the Governor at least two physicians for each vacancy. Dr. McLoughlin stated that at the present time there are three vacancies on the Board created by the expirations of the terms of office of three physicians. Dr. McLoughlin then asked consideration of six nominations to fill the three vacancies.

By general agreement this matter was referred to the Executive Committee for nomination as desired by the Governor.

After some discussion, it was moved on motion duly made and seconded that any future appointments by the MAG to State Boards and State Committees be nominated by the Executive Committee of Council. This motion was approved.

Lectureship Presented

Chairman J. G. McDaniel reported that he was presenting a lectureship request from Dr. Murdock Equen who was unable to attend this meeting. Dr. McDaniel stated that Dr. Equen had wished to institute a lectureship at the Medical Association of Georgia Annual Meetings and that Dr. Equen had discussed this matter thoroughly with the Lectureship Committee. According to the ground rules approved by Council as presented by the Lectureship Committee, it was Council's prerogative to approve any Lectureship proposed for the Association and to set an amount for such Lectureship fund which would support the proposed Lectureship. On motion (Alexander-Hatcher) it was voted to approve the Jonte Equen Memorial Lectureship at MAG Annual Sessions and further recommend that this Lectureship be set up according to the ground rules for MAG Lectureships and that an amount of \$6,000 be donated by the sponsor of the Lectureship in like manner as the Calhoun Memorial Lectureship.

Dr. George Alexander, Chairman of the Lectureship Committee then reported that there will be no McRae Lectureship at the 1960 Annual Session.

Headquarters Office Report

Mr. Krueger brought to the attention of the members of Council the fact that some three years ago Council had approved "Automobile Bumper Safety Stickers" which bore the seal of the Association. Mr. Krueger reported that the supply of these stickers was exhausted. These safety stickers were furnished to the present membership of MAG and new members free and after this initial mailing of stickers, they were then available to members at a nominal fee. Mr. Krueger asked for instruction as to future supply of said stickers.

On motion duly made and seconded it was voted that a new re-order of Safety Stickers be purchased and that the funds for this expenditure be taken from the Contingent Fund.

Mr. Krueger reported that the matter of new office equipment had been deferred until this meeting and stated that there was a recommendation for a new IBM electric typewriter and a multilith machine. After discussion on motion duly made and seconded it was voted to purchase a new IBM electric typewriter and a multilith machine, with the provision that the present mimeograph machine be sold to the Fulton County Medical Society for the amount of \$375. The motion further stated that funds for the purchase of the electric typewriter

and multilith machine were to be paid from the Contingent Fund.

Other Business

President Wolff discussed the civic responsibilities of physicians. He emphasized that physicians should be active in seeking office on the community and state level. By general agreement it was recommended that physicians be encouraged to seek and take part in civic and political activities in their community and the State of Georgia.

President Wolff discussed an insurance coverage for any MAG member carrying on Association business that would cover this physician in the event of an accident. After discussion on motion duly made and seconded this matter was referred to the Insurance Committee for study and the Insurance Committee was requested to report back to the Council with a recommendation on this type of insurance.

Chairman McDaniel recessed the October 10, 1959 session of the Council at 5:30 P.M.

RECONVENED COUNCIL MEETING

OCTOBER 11, 1959

Chairman McDaniel called to order the reconvened meeting of the Council of the Medical Association of Georgia at 9:05 A.M. Sunday, October 11, 1959 at the Gardens Motel, Pine Mountain, Georgia.

In addition to those members of Council present Saturday, October 10, were the following: J. Frank Walker, Atlanta, Chairman Legislation Committee; John S. Atwater, Atlanta, Chairman Health Care of the Aging Committee.

Talmadge Hospital Liaison Committee

Dr. Charles Richardson, Sr., Chairman of the Talmadge Hospital Liaison Committee, reviewed the present status of Liaison between the Medical College of Georgia and the Richmond County Medical Society. He was assured the cooperation of the Association in arranging a meeting of this Committee.

Eighth District Meeting Report

Eighth District Councilor F. G. Eldridge reported that members of the Eighth District requested activity of Council on the implementation of Resolution No. 12 as approved by the House of Delegates at their 1959 Session. Resolution No. 12 as approved by the House of Delegates reads as follows:

"NOW THEREFORE, BE IT RESOLVED that the House of Delegates create a Committee on Medicare and other governmental medicines which shall consist of one physician representative from each District of the State to be appointed by the President of the District Society for a term of three years. This Committee shall meet at least semi-annually, consider problems which arise, consider renegotiating problems and other such problems and make recommendations to the Executive Committee for their consideration and final action."

After discussion of the implementation of this Resolution on motion (Alexander-Dillinger) it was voted that Executive Committee expedite the carrying out and clarification of this Resolution.

Dr. Eldridge also reported that it was the recommendation of the Eighth District Medical Society that the Association recommend a higher liability limit in the present Workman's Compensation Law. Dr. Eldridge was assured by the Chairman of Council that this matter has already been referred to the Industrial Health Committee and the Legislative Committee for study and action. The Executive Secretary was then instructed to write the Eight District Officers about these two items referred to Council by the Eighth District.

Lectureship Committee Addendum Report

Chairman of the Lectureship Committee, George Alexander recommended that Council write Dr. Floyd McRae, thanking him for consideration for an annual session Lectureship, and expressing the Council's regret that at the present time he did not see fit to establish such lectureship. This motion was approved.

Public Service Committee Report

Dr. John Heard, Chairman of the Association Public Service Committee reported on plans and program for an Association Automobile Highway Safety Program. He presented the problem and emphasized legislative aspects and their necessity. He further requested \$1,000 appropriation to implement this safety program. After general discussion on motion (Goodwin-Wolff) it was voted that the Council endorse the Public Service Committee Program and agrees to sponsor only the part of the program that pertains to the field of medicine and that \$1,000 be appropriated from the Contingent Fund to implement this Safety Program.

Legislative Committee Report

Dr. J. Frank Walker, Chairman of the Association Legislative Committee reported on the activity considered by his Committee at their October 7 meeting. This data was accepted for information. Also for information, Dr. Walker reported on the AMA Legislative Conference held in St. Louis, Missouri, October 2-3, 1959. At this time Dr. Walker introduced Mr. Charles Johnson, AMA Field Staff Representative, who presented a film-strip recording from Dr. Louis Orr, President of the American Medical Association on the subject of HR 4700 (Forand bill). Mr. Johnson also reported on the AMA activity and the responsibility of State Medical Associations in connection with the Forand bill.

Dr. Walker then called on Mr. John Kiser, Associate Executive Secretary, who emphasized national legislative activities and the Association position and activity on these matters.

Health Care of the Aging Committee Report

Dr. John S. Atwater, Chairman of the Association Health Care of the Aging Committee, reported on the activity and function of the Georgia Joint Council; the creation and function of the Governor's Commission on Aging and the Executive Order of the Governor of the State of Georgia initiating this Commission and other meetings on Health Care of the Aging in which Dr. Atwater participated.

Dr. Atwater then proposed the MAG sponsorship of a Health Care of the Aging meeting to be held in Atlanta on Sunday, November 15 at which time the Presidents and Secretaries of the seven-component county societies would be invited to participate. Dr. Atwater discussed the plans and programs of this meeting and on motion (Wolff-Thomas) it was voted to proceed with the plans and programming of such a meeting and the necessary funds for the sponsoring of such a meeting to be appropriated from the Contingent Fund.

At this time Chairman McDaniel recognized Legislative Committee Chairman Dr. J. Frank Walker who outlined the need for additional funds to carry on the activity of the Legislation Committee. On motion (Goodwin-Alexander) it was voted to appropriate \$500 from the Contingent Fund for the Legislative Committee.

Unfinished Business

Secretary Chris J. McLoughlin presented a request from Pan American Airlines for the publication of a questionnaire to be filled out by the membership in the *Journal of the Medical Association of Georgia* concerning a post convention cruise, and on motion duly made and seconded this request was so approved.

New Business

Secretary Chris J. McLoughlin read a communication from Mr. E. T. Methvin, Editor and Publisher of the *Times Journal*, Eastman, Georgia. After discussion of this letter concerning an emergency call system, on motion (Thomas-Wolff) it was voted that the Councilor from the Third District advise with the physicians in the area on this problem.

President Wolff discussed certain cultists problems affecting the public welfare in the State of Georgia and by general agreement it was moved to refer this matter to the Executive Committee of Council for action.

Dr. David R. Thomas, Chairman of the Insurance and Economics Committee discussed the method of transfer of the Association's three insurance programs for its membership from the Provident Life Insurance Company to the Life Insurance Company of Georgia. By general agreement it was recommended that Dr. Thomas write Provident of the action on this matter.

The site and date of the next Council meeting was discussed and on the invitation of Dr. F. G. Eldridge, Councilor of the Eighth District, the Council was invited to hold their next

meeting in Valdosta on December 12-13, 1959. This invitation was accepted by the Council with thanks to Dr. Eldridge for his recommendation.

On motion duly made and seconded and with a rising vote of appreciation the Council members voted their sincere thanks and appreciation to Dr. and Mrs. Chambers and Dr. and Mrs. Elliott as hosts to the Council on the occasion of this meeting. The Secretary of the Association was asked to write a most gracious letter of appreciation to Drs. Chambers and Elliott.

There being no further business Chairman McDaniel adjourned the meeting at 11:50 A.M.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE MONTHLY MEETING of the Executive Committee of Council of the Medical Association of Georgia was called to order at 12:00 noon by President Luther Wolff on Sunday, October 11, 1959 at the Gardens Motel, Pine Mountain, Georgia.

Members of the Executive Committee present included: President Luther H. Wolff; President-Elect Milford Hatcher; Secretary Chris J. McLoughlin; Chairman of Council J. G. McDaniel; and Chairman of Finance Virgil Williams.

Also present were Messrs. Krueger and Kiser of the Headquarters Office Staff.

Cultist Problem

President Wolff discussed the cultist problem referred by Council to Executive Committee and on motion (McDaniel-Williams) it was voted to refer the problem to legal counsel for a plan of procedure and further a request that legal counsel report back to the Executive Committee at their next meeting.

Workman's Compensation Medical Board Appointments

By general agreement it was voted to recommend Dr. Hugh Haley and Dr. Hiram Sturm; Dr. Duncan Shepard and Dr. Darrel Ayer; and Dr. Walter T. Sale and Dr. Albert Rayle, Sr. as the six nominations to fill the three vacancies on the Workman's Compensation Board under the provisions of Section 114-822 of the Code of Georgia and submit these nominations to the office of the Governor as requested in a communication of October 1 from the Executive Department State of Georgia.

Governmental Medicine Committee

President Wolff discussed Resolution No. 12 as approved by the House of Delegates at their 1959 Session which was referred to the Executive Committee for action. On motion duly made and seconded it was recommended that a letter be sent to each District President requesting appointment of a representative to serve on this Committee with the suggestion that the present Medicare District Representative be considered for this appointment.

New Headquarters Office Floor Plan

President Wolff and the members of the Executive Committee discussed a proposed floor plan for the occupancy of the new Headquarters Office and by general agreement the matter was tabled until the next monthly meeting of the Executive Committee of Council.

Site and Date of Next Executive Committee Of Council Meeting

By general agreement it was approved that the Executive Committee of Council meeting in Atlanta on November 15, 1959 with the actual time of the meeting to be set by Secretary Chris J. McLoughlin.

There being no further business the Executive Committee of Council adjourned at 12:20 P.M.

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Guests: Dr. Laurence Hester, Chairman, Department of Obstetrics-Gynecology, University of South Carolina Medical College.

Dr. John D. Thompson, Associate Professor of the Department of Obstetrics-Gynecology, Emory University, Atlanta

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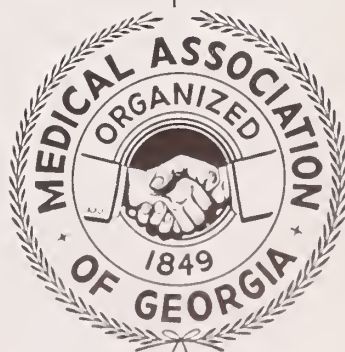
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JOURNAL OF THE MEDICAL ASSOCIATION

Georgia

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